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ALEXANDER L. STEVAS,
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Nos. 81-746 and 81-1172

IN THE

SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1981

CITY OF AKRON,

Petitioner,

v.

AKRON CENTER FOR REPRODUCTIVE HEALTH, INC., *ET AL.*,

Respondents.

AKRON CENTER FOR REPRODUCTIVE HEALTH, INC., *ET AL.*,

Cross-Petitioners

v.

CITY OF AKRON, *ET AL.*,

Respondents.

ON WRITS OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

JOINT APPENDIX

[Counsel Listed on Inside Cover]

Washington, D.C. • THIEL PRESS • (202) 638-4521

Petition for Certiorari in No. 81-746 Filed October 13, 1981
Petition for Certiorari in No. 81-1172 Filed December 19, 1981
Certiorari Granted May 24, 1982

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17 Akron Center for Reproductive Health Demographics on Parental Knowledge, December 1977-July 1978, admitted at Trial, T. I, 172, 228 ..... 287a

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37 WomenCare Patient Informed Consent Form, admitted at Trial, T. III, 34, 35 . . . . . 297a

45 Chapter 3701-47 ("Abortions" of Ohio Administrative Code), definition and section governing counseling, admitted at Trial, T. I, 22 . . . . . 299a

46 Akron City Hospital Abortions—Elective and Therapeutic, admitted at Trial, T. IV, 137, 140 . . 300a

47 Akron General Medical Center Report on Abortions, dated August 25, 1978, covering May 1977-April 1978, admitted at Trial, T. IV, 22, 25 . . . . . 301a

48 Statement by C. William Keck, M.D., M.P.H., to Akron City Council Health & Social Service Committee, dated February 4, 1978, with attached article, admitted at Trial, T. V, 50 . . . . . 304a

50 Statement on Abortion Ordinances by Dr. Charles Bowen, speaking for the Summit County Medical Society, admitted at Trial, T. II, 36, 37 . . . . . 317a

51 Statement by Akron Mayor John S. Ballard, dated March 8, 1978, on his decision to allow Ordinance No. 160-1978 to become law without his signature, admitted at Trial, T. III, 7 . . . . . 320a

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The following opinions have been omitted in printing this appendix because they appear on the following pages in the appendix to the Printed Petition for Certiorari:

Opinion of the United States District Court, Northern District of Ohio, Eastern Division, at 43a-106a

Order of the United States District Court, Northern District of Ohio, Eastern Division, on Motion for New Trial, at 107a-111a

Opinion of the United States Court of Appeals for the Sixth Circuit, at 1a-42a

DOCKET ENTRIES
Case No. C78-155A

4-19-78

1. *Complaint* (Class action) filed. Summons issued. Four copies of complaint with four copies of summons issued to U.S. Marshal 4-19-78.

2. *Motion* of plaintiff for a TRO filed. Four copies issued to U.S. Marshal 4-19-78.

2A. *Exhibits* to plaintiffs' motion for TRO filed. Four copies issued to U.S. Marshal 4-19-78.

Three Sealed Envelopes bearing return address of Cleveland State University with true name affidavit of Wanda Woe, Dr. Doe and Lori Lee lodged.

3. *Motion* of plaintiff and memorandum in support of certification as a class action filed. Four copies issued to U.S. Marshal 4-19-78.

4. *Motion* of plaintiff to present affidavit of plaintiff Doe in a sealed envelope with memorandum in support and attachments filed. Four copies issued to U.S. Marshal 4-19-78.

5. *Notice of Hearing* on plaintiffs' motion for TRO at 3 p.m. on 4-27-78 filed. Copies (4) issued to U.S. Marshal & copies mailed 4-20-78.

4-20-78

6. *Order* that defendants file response to plaintiffs' motion to certify action as a class action by 5-1-78 at 9 a.m. filed. Contie, J. Four certified copies issued to U.S. Marshal and copies mailed to plaintiffs' counsel 4-20-78.

4-25-78

7. *Notice* of plaintiffs to take deposition of Robert L. Goehler at 9 a.m. on 5-2-78 filed. Copy mailed 4-25-78.

8. *Motion* of plaintiffs to take deposition prior to expiration of thirty days with memorandum in support filed. Copy mailed 4-25-78.

9. *Supplemental Memorandum* in support of plaintiffs' motion for class action certification filed. Copy mailed 4-25-78.

10. *Supplemental Memorandum* in support of plaintiffs' motion for TRO with attachments filed. Copy mailed 4-25-78.

4-26-78

11. *Petition* to intervene of Francois Seguin, M.D. & Patricia K. Black with Memorandum in support and attachments filed.

4-27-78

12. *Memorandum* of defendants in opposition to TRO filed. Copies mailed 4-27-78.

13. *Affidavit* of Kathy Gotshall filed. No service.

14. *Affidavit* of Starlett C. Hurst filed.

15. *Order* denying motion of plaintiffs to retain true name affidavit of plaintiff Dr. Doe, a pseudonym. Further, pltfs. are granted five days from date of this Order to amend their complaint filed. Contie, J. Copies hand delivered 4-27-78.

16. *Minutes* of proceedings filed. Contie, J. Kraemer, r. Heard by the Court 4-27-78. Total trial time: 40 min. TRO hearing.

4-28-78

17. *Order* granting motion of plaintiffs' for TRO. Hearing on application for preliminary injunction is consolidated with trial on merits, & such is scheduled for 5-30-78 at 9 a.m. filed. Contie, J. Copies mailed 4-28-78.

5-2-78

18. *Marshal's Return* re (4) Summons & complaint filed. Served John S. Ballard, 4-21-78, Dr. C. Wm. Keck, Peter Oldham, 4-24-78, and City of Akron, 4-21-78. Fees $36.72.

19. *Letter* from James L. Bickett with letter (copy) attached from Mr. Bickett to Wayne G. Hawley indicating Robert Goehler has 10 cassette tapes of public hearings.

20. *First Amended Complaint* filed. Copies mailed 5-2-78.

21. *Memorandum* of plaintiffs in opposition to petition to intervene filed. Copies mailed 5-2-78.

5-3-78

22. *Answer* of deft. City of Akron, John S. Ballard, Dr. C. Wm. Keck, and Peter Oldham to petition to intervene of Francois Seguin, M.D. and Patricia K. Black filed. Copies mailed 5-3-78.

23. *Order* striking amended complaint. Plaintiffs shall be granted leave to amend their complaint by 5-8-78 at 9 a.m. Further, if plaintiffs seek to assert class action, they shall move for class certification by 5-12-78 & defts. shall respond thereby by 5-18-78 filed. Contie, J. Copies mailed 5-3-78.

24. *Motion* of plaintiffs to present affidavit of plaintiff Loe in a sealed envelope with memorandum in support and attachment filed. Copies mailed 5-3-78.

    Sealed Envelope bearing return address of American Civil Liberties Union of Ohio with true name affidavit of Linda Loe lodged.

5-4-78

25. *Motion* of plaintiffs for reconsideration of Court's order of 5-3-78 with Brief in support filed. (With attachments). Copies mailed 5-4-78.

5-5-78

26. *Order* denying motion of plaintiffs to reconsider Court's Order of 5-3-78 filed. Contie, J. Copies mailed 5-5-78.

5-8-78

27. *Second Amended Complaint* filed. Copies mailed 5-8-78.

5-10-78

28. *Motion* of plaintiffs to certify an Order pursuant to 28 U.S.C. § 1292(b) with Brief in support filed. Copies mailed 5-10-78.

5-15-78

29. *Motion* of plaintiffs to certify Order of 4-27-78 with Brief in support filed. Copies mailed 5-15-78.

5-16-78

30. *Order* that the Motion of Dr. Francois Seguin, M.D. & Patricia K. Black for leave to intervene as parties deft. is granted in part and denied in part filed. Contie, J. Copies mailed 5-16-78.

31. *Order* denying motion of plaintiffs for the Court to amend its Order of 4-27-78 certifying to USCA for the Sixth Circuit the question of propriety of denying physician leave to proceed by pseudonym filed. Contie, J. Copies mailed 5-16-78.

32. *Order* denying motion of plaintiffs for the Court to amend its Order of 5-3-78 to certify to USCA

for the Sixth Circuit the question of propriety of denying a pregnant woman leave to proceed by pseudonum filed. Contie, J. Copies mailed 5-16-78.

33. *Order* finding motion of plaintiffs to allow Linda Loe to proceed under pseudonym to be moot filed. Contie, J. Copies mailed 5-16-78.

34. *Order* finding motion of plaintiffs to certify this action as a class action on behalf of all physicians licensed to practice medicine in State of Ohio, within City of Akron, who do not or may in future terminate pregnancies by abortion to be moot filed. Contie, J. Copies mailed 5-16-78.

5-18-78

35. *Motion* of defendants to continue hearing on final merits & consent to a Temporary Injunction filed. Copies mailed 5-18-78.

5-19-78

36. *Answer* of intervenors Francois Seguin, M.D. & Patricia K. Black to Second Amended complaint filed. Copies mailed 5-19-78.

37. *Answer* of defts. City of Akron, John S. Ballard, Dr. C. Wm. Keck, and Peter Oldham filed. Copies mailed 5-19-78.

35. *Motion* of defendants to dismiss filed. Copies mailed 5-19-78.

39. *Memorandum* in support of defts' motion to dismiss filed. Copies mailed 5-19-78.

40. *Interrogatories* of defts. to pltf. Akron Center for Reproductive Health, Inc. filed. Copies mailed 5-19-78.

41. *Interrogatories* of defts. to pltf. WomenCare, Inc. filed. Copies mailed 5-19-78.

42. *Interrogatories* of defts. to pltf. Akron Women's Clinic, Inc. filed. Copies mailed 5-19-78.

43. *Motion* of defts. to have interrogatories answered within 3 days of service filed. Copies mailed 5-19-78.

44. *Motion* of plaintiffs to file a third amended complaint with memorandum in support and attachments filed. Copies mailed 5-19-78.

45. *Affidavit* of Stephan Landsman in opposition to motion to continue hearing filed. Copies mailed 5-18-78.

5-22-78

46. *Memorandum* of defendants in opposition to plaintiffs' motion to file a third amended complaint filed. Copies mailed 5-22-78.

5-23-78

47. *Order* granting motion of defts. for continuance of trial & action is hereby rescheduled for on or after 9-5-78. Further, all discovery shall be completed by 7-3-78 & all motions shall be filed by 7-17-78 filed. Contie, J. Copies mailed 5-23-78.

5-30-78

Endorsed Order overruling motion of defendants to have interrogatories answered within 3 days of service filed. Contie, J. Copies mailed 5-30-78.

6-2-78

48. *Requests* of plaintiffs for admissions to defts. City of Akron, Ballard, Keck & Oldham filed. (With attachments). Copies personally deliv. 6-2-78.

49. *Interrogatories* of plaintiffs to defts. City of Akron, Ballard, Keck & Oldham filed. Copies personally delivered 6-2-78.

50. *Request* of plaintiffs for admissions to defts. Seguin & Black filed. Copies personally delivered 6-2-78.

51. *Interrogatories* of plaintiffs to defts. Francois Seguin, M.D. & Patricia K. Black filed. Copies personally delivered 6-2-78.

6-5-78

52. *Notice* of change of address of Wayne G. Hawley, atty. for pltfs., filed. Copies mailed 6-1-78.

53. *Requests* of deft. City of Akron for admission to pltfs. filed. Copies mailed 6-2-78.

54. *Interrogatories* of deft. City of Akron (Second set) to pltfs. filed. Copies mailed 6-2-78 and copy hand delivered 6-2-78.

55. *Motion* of defts. requesting shorter time for responding to defts.' requests filed. Copies mailed 6-5-78.

56. *Request* (First) of defts. for production by pltf. Akron Center for Reproductive Health, Inc. filed. Copies mailed 6-2-78.

57. *Request* (First) of defts. for production by pltf. WomenCare, Inc. filed. Copies mailed 6-2-78.

58. *Request* (First) of defts. for production by pltf. Akron Women's Clinic, Inc. filed. Copies mailed 6-2-78.

59. *First Set* of Request for admissions by Intervenors to pltf. WomenCare, Inc. filed. Copies mailed 6-1-78.

60. *Request* for admissions (First set) by intervenor to pltf. Reproductive Health, Inc. filed. Copies mailed 6-1-78.

61. *Request* for admissions (First set) by intervenor to pltf. Akron Women's Clinic, Inc. filed. Copies mailed 6-1-78.

62. *Motion* of deft.-intervenors requesting shorter time for responding to deft.-intervenors' discovery requests filed. Copies mailed June 2, 1978.

63. *Request* of deft.-intervenors for production of documents & tangible things filed. Copies mailed 6-2-78.

64. *Interrogatories* (First set) of deft.-intervenors filed. Copies mailed 6-2-78.

65. *Requests* of deft.-intervenors (Second set) for admission filed. Copies mailed 6-2-78.

66. *Memorandum* of plaintiff in opposition to deft.'s motion to dismiss filed. Copies mailed 6-1-78.

6-7-78

67. *Notice* of defts. to take deposition of Norma M. Goldberger at 1:15 p.m. on 6-13-78 filed. Copies mailed 6-7-78.

68. *Notice* of defts. to take deposition of Kathy Gotshall at 9 a.m. on 6-13-78 filed. Copies mailed 6-7-78.

69. *Notice* of defts. to take deposition of Starlett C. Hurst at 10:30 a.m. on 6-13-78 filed. Copies mailed 6-7-78.

6-8-78

70. *Opposition* of plaintiffs to motion of deft.-intervenor to shorter time for discovery filed. Copies mailed 6-7-78.

6-12-78

71. *Supplemental Memorandum* of plaintiffs in opposition to defts.' motion to dismiss filed. Copies mailed 6-9-78.

72. *Brief* of intervenors in support of motion of deft.-intervenors to shorten time for responding to discovery requests filed. Copies mailed 6-12-78.

73. *Notice* of plaintiffs to take deposition of Roger Sherman at 1:30 p.m.; Dr. John Dettling, 2 p.m.; Dr. Wm. Cook, 3 p.m.; Dr. Edward F. Helwig, 4 p.m. on 6-28-78 filed. Copies mailed June, 1978 (Day omitted).

74. *Notice* of plaintiffs to take deposition of Robert Goehler at 9:30 a.m.; Ray Kapper, 11 a.m.; Alan G. Segedy, 1:30 p.m.; and Marvin Weinberger at 3 p.m. on 6-19-78 filed. Copies mailed June, 1978 (Day omitted).

75. *Returns* re (3) Deposition subpoenas filed. Served Norma M. Goldberger, Starlett C. Hurst, and Kathy Gotshall on 6-8-78. Fees $_____.

6-15-78

76. *Objection* of plaintiffs to inspection and copying of documents filed. Copies mailed 6-12-78.

6-16-78

77. *Reply* of plaintiffs to intervenors' brief in support of motion to shorten time filed. Copies mailed 6-15-78.

6-20-78

78. *Motion* of respondent, real parties in interest to quash subpoenas directed to real parties in

interest & for a protective order with Brief in support filed. Copies mailed 6-16-78.

6-21-78

79. *Application* of notary public, advice & instructions re: Deposition of Norma M. Goldberger filed.

80. *Application* of notary public, advice & instructions re: Deposition of Starlett C. Hurst filed.

81. *Application* of notary public, advice & instructions re: Deposition of Kathleen Gotshall filed.

6-23-78

82. *Motion* of defts. City of Akron, Dr. Keck, John Ballard & Peter D. Oldham to compel Norma Goldberger to answer certain questions filed. Copies mailed 6-22-78.

83. *Affidavit* of James L. Bickett in support of Motion to compel filed. Copies mailed 6-22-78.

84. *Motion* of defts. City of Akron, Dr. Keck, John Ballard & Peter D. Oldham to compel Starlett C. Hurst to answer certain questions filed. Copies mailed 6-22-78.

85. *Affidavit* of James L. Bickett in support of Motion to compel filed. Copies mailed 6-22-78.

86. *Motion* of defts. City of Akron, Dr. Keck, John Ballard, Peter D. Oldham for Order to compel Kathy Gotshall to answer certain questions filed. Copies mailed 6-22-78.

87. *Affidavit* of James L. Bickett in support of motion to compel filed. Copies mailed 6-22-78.

88. *Memorandum* of defts. City of Akron, Dr. Keck, John Ballard & Peter D. Oldham in support of motion to compel filed. Copies mailed 6-22-78.

89. *Motion* of plaintiff to reconsider order denying certification filed. Copies mailed 6-22-78.

90. *Motion* to quash subpoenas issued to Dr. John Dettling and Dr. Wm. Cook or, in the alternative, motion to advance costs filed. Copies mailed 6-23-78.

91. *Affidavit* of Betty Ragan filed. Copies mailed 6-23-78.

92. *Affidavit* of Faith Lower filed. Copies mailed 6-23-78.

6-27-78

93. *Notice* of deposition of person designated by Department of Health of the State of Ohio on 7-3-78 at 10:00 a.m. Copies mailed 6-27-78.

94. *Return* re deposition subpoena (7) filed. Served Alan Segedy on 6-12-78, Robert C. Goehler on 6-12-78, Edward Helwig on 6-14-78, Roger Sherman at Children's Hospital on 6-15-78, Dr. John Dettling on 6-14-78, Dr. William Cook on 6-21-78, Marvin Weinberger on 6-13-78. Fees $_____.

6-28-78

95. *Response* of plaintiffs to first request for production propounded by city defendants filed. Copies mailed 6-27-78.

96. *Response* of plaintiffs to request for production of documents and tangible things propounded by defendant-intervenors filed. Copies mailed 6-27-78.

97. *Response* of plaintiffs to motion to quash subpoenas issued to Drs. Bettling and Cook filed. Copies mailed 6-27-78.

6-29-78

98. *Initial Response* of plaintiff to city defendants' motion to compel answers from deponent clinic directors filed. Copies mailed 6-28-78.

6-30-78

99. *Memorandum* of plaintiffs of points and authorities in opposition to non-party respondent's motion to quash subpoenas and for a protective order with attachments filed. Copy mailed 6-29-78.

100. *Responses* of plaintiff Akron Center for Reproductive Health, Inc. to first set of Interrogatories propounded by City defts. with attachment filed. Copies hand delivered 6-30-78.

101. *Responses* of pltf. Akron Center for Reproductive Health, Inc. to deft.-intervenors' first set of interrogatories filed. Copies hand delivered 6-30-78.

102. *Response* of all plaintiffs to second set of interrogatories of City defendants filed. Copies hand delivered 6-30-78.

103. *Responses* of pltf. Akron Women's Clinic, Inc. to first set of interrogatories by City defendants filed. Copies hand delivered 6-30-78.

104. *Responses* of plaintiffs to intervenors' first set of requests for admissions filed. Copies hand delivered 6-30-78.

105. *Responses* of plaintiff WomenCare, Inc. to first set of interrogatories propounded by City defendants filed. Copies hand delivered 6-30-78.

106. *Response* of plaintiff WomenCare, Inc. to deft.-intervenors' first set of interrogatories filed. Copies hand delivered 6-30-78.

107. *Responses* of plaintiffs to intervenors' second set of requests for admissions filed. Copies mailed 6-30-78.

108. *Response* of plaintiff Akron Women's Clinic, Inc. to deft.-intervenors' first set of interrogatories filed. Copies hand delivered 6-30-78.

7-3-78

109. *Affirmation* in support of subpoena—respondents motion to quash and for a protective order filed. Copies mailed 6-30-78.

110. *Motion* of deft.-intervenors to compel answers to questions asked on oral deposition with memorandum in support filed. Copies mailed 7-3-78.

111. *Answers* of defts. Francois Seguin, M.D. & Patricia K. Black to plaintiff's interrogatories filed. Copies mailed 7-3-78.

112. *Answers* of defts. Francois Seguin, M.D. & Patricia K. Black to plaintiff's interrogatories filed. Copies mailed 7-3-78.

113. *Answers* to request for admission to defts. Seguin & Black filed. Copies mailed 7-3-78.

114. *Answers* of defendants to plaintiffs' interrogatories filed. Copies mailed 7-3-78.

115. *Answers* of defendants to plaintiffs' requests for admission filed. Copies mailed 7-3-78.

7-6-78

116. *Motion* of defendants to compel answers to interrogatories & to compel production of documents with Memorandum in support and Affidavit filed. Copies mailed 7-6-78.

7-7-78

117. *Oppostion* of plaintiffs to Motion to Compel Further Answers to Questions Aksed on Oral Deposition filed. Copy mailed 7-7-78.

7-11-78

118. *Affidavit* of Ruth Harris filed. Copies mailed 7-11-78.

7-13-78

119. *Order* denying motion of Raymond Kapper, Robert Goehler, Alan Segedy and Marvin Weinberger to quash subpoenas served on them and for a protective order filed. Copies mailed 7-13-78. Contie, J.

120. *Order* that motion of defendants and defendant-intervenor to compel answers and award of expenses be granted in part and denied in part. Motion for award of expenses is denied, Motion to compel answers are granted, with protective order filed. Contie, J. Copies mailed 7-13-78.

121. *Order* denying motion of plaintiffs for leave to file a third amended complaint filed. Contie, J. Copies mailed 7-13-78.

122. *Order* denying motion of Plaintiffs that Court reconsider order of 5-16-78 denying certification to the USCA for the Sixth Circuit filed. Contie, J. Copies mailed 7-13-78.

7-17-78

123. *Motion* of defendants for Partial Summary Judgment filed. Copies mailed 7-17-78.

124. *Motion* of Defendant-Intervenors to compel discovery with affidavit and Memorandum in

support filed. Copies mailed 7-15-78. (With attachments).

125. *Motion* of respondent for leave to file a reply to Plaintiffs' brief in opposition to respondents' motion to quash and for a protective order filed. Copies mailed 7-12-78.

126. *Brief* in support of Defendants' Motion for Partial Summary Judgment filed.

127. *Depositions* of Kathleen Gotshall, Starlett C. Hurst, and Norma C. Goldberger with attachments filed.

128. *Motion* for leave to proceed as amici curiae on behalf of plaintiffs filed. (With Memorandum in support). Copies mailed 7-17-78.

129. *Motion* of defendants to determine sufficiency of answers & objections to requests for admissions with memorandum in support filed. Copies mailed 7-17-78.

130. *Motion* of defendants to extend time to 8-11-78 for discovery with memorandum in support filed. Copies mailed 7-17-78.

131. *Motion* of plaintiffs to file fourth amended complaint with memorandum in support and attachment filed. Copies mailed 7-17-78.

132. *Motion* of plaintiffs for partial summary judgment with memorandum in support and attachments filed. Copies mailed 7-17-78.

133. *Motion* of plaintiffs for the setting of a date certain for hearing filed. Copies mailed 7-17-78. End. Ord. overruling motion 7-28-78. Copies mailed 7-28-78.

7-18-78

134. *Memorandum* of defendants City of Akron, John S. Ballard, Dr. C. William Keck and Peter Oldham in opposition to Plaintiffs' motion to file a fourth amended complaint filed. Copies mailed 7-18-78.

135. Defendants The City of Akron, John S. Ballard, Dr. C. William Keck and Peter Oldham, response to Plaintiffs' Motion for the setting of a date certain filed. Copies mailed 7-18-78.

7-20-78

136. *Response* of plaintiffs to motion of city defendants to compel answers to interrogatories and to compel production of documents filed. Copies mailed 7-18-78.

7-24-78

137. *Response* of all plaintiffs to City Defendants' Requests for Admissions filed. Copies mailed 7-20-78.

7-26-78

138. *Memorandum* of plaintiffs in opposition to city defendants' motion for partial summary judgment filed. Copies mailed 7-25-78.

139. *Memorandum* of plaintiffs in opposition to city defendants' motion to determine sufficiency of answers and objections to requests for admissions filed. Copies mailed 7-25-78.

140. *Application* ex parte for order enlarging time filed. Copies mailed 7-26-78.

7-27-78

141. *Memorandum* of plaintiffs in opposition to defendant-intervenors' motion to compel discovery filed. Copies mailed 7-26-78.

142. *Order* granting enlargement of time on ex parte application of defendants, and extending time to 8-2-78 filed. Contie, J. Copies mailed 7-28-78.

7-28-78

143. *Memorandum* of defendants in opposition to motion for leave to proceed as Amici Curiae on behalf of plaintiffs filed. Copies mailed 7-20-78.

144. *Order* granting motion of defendants to extend discovery to 8-11-78 filed. Contie, J. Copies mailed 7-28-78.

145. *Order* granting request of Raymond Kapper, Robert Goehler, Alan Segedy, and Marvin Weinberger to withdraw Brief in opposition to motion to quash and for a protective order filed. Contie, J. Copies mailed 7-28-78.

146. *Order* granting motion of plaintiffs for leave to file a fourth amended complaint filed. Contie, J. Copies mailed 7-28-78.

147. *Fourth Amended Complaint* of plaintiffs filed. No service.

148. *Order* granting National Abortion Rights League and the American Public Health Association leave to proceed as amici curiae to file brief in pltfs.' behalf. Also, denying unnamed individual physicians and health professionals leave to proceed as amici curiae. Also, physicians and health professionals have 10 days to file motion to proceed as amici curiae in accordance with conditions filed. Contie, J. Copies mailed 7-28-78.

7-31-78

149. *Brief* of defendant-intervenors in opposition to plaintiffs' motion for partial summary judgment filed.

150. *Request* of plaintiff for production of documents from city defts. filed. Copies mailed 7-28-78.

151. *Motion* of deft. to reconsider Order permitting Amici Curiae to proceed filed. Copies mailed 7-31-78.

8-1-78

152. *Motion* of plaintiffs for Ellen Leitzet to appear as counsel filed. Copies mailed 7-31-78. End. Ord. Granting. Contie, J. Copies mailed 8-22-78.

8-2-78

153. *Order* denying motion of Defendant-Intervenors to compel discovery filed. Contie, J.

154. *Order* denying in part, and granting in part, defendant's motion to compel discovery. Pltfs. must respond to #8, 12, 16, 21, 24, & 27 of defts.' 1st set of interrogatories, and #21 & 22b of defts.' 2nd set of interrogatories within 5 days of date of order. Further, pltfs. must produce documents in categories 1-5 of defts.' 1st request for prod. of documents within 5 days of date of order filed. Contie, J.

8-1-78

155. *Order* granting defts.' motion to determine Sufficiency of Answers and Objections to Requests for Admissions. Pltfs. ordered to respond to #12, 13, 14, 15, 16, 17, 19, & 56 of defts.' request for admissions within 5 days of date of order filed. Contie, J. Copies mailed 8-1-79.

8-2-78

156. *Brief* of Defendant-Intervenors in support of defendant's Motion for Summary Judgment filed. (With affidavit and attachments). Copies mailed 8-2-78.

157. *Memorandum* of defendants in opposition to plaintiffs' motion for partial summary judgment filed. Copies mailed 8-2-78.

158. *Notice* of deposition of defendants of Dr. Robert Bliss, M.D. on 8-9-78, at 2 p.m. filed. Copies mailed 8-2-78.

8-7-78

159. *Answer* of defts. City of Akron, John S. Ballard, Dr. C. William Keck, and Peter Oldham filed. Copies mailed 8-7-78.

8-14-78

160. *Answer* of intervenors to Fourth Amended complaint filed. Copies mailed 8-14-78.

8-17-78

161. *Motion* of Applicants for enlargement of time to file motion to proceed as amici curiae on behalf of plaintiffs with memorandum in support filed.

8-18-78

162. *Order* denying motions of defts. and deft.-intervenors' requests for a shorter time for responding to defendant-intervenors. Discovery Requests filed. Contie, J. Copies mailed 8-22-78.

163. *Order* denying motion of defts. to reconsider order of 7-28-78 granting NARAL and APHA leave to proceed as amici curiae filed. Contie, J. Copies mailed 8-22-78.

164. *Order* denying motion of deft. without prejudice to seek dismissal of plaintiffs' fourth amended complaint for lack of standing filed. Contie, J. Copies mailed 8-22-78.

8-23-78

165. *Supplemental Responses* of plaintiffs to first and second set of interrogatories propounded by city defendants filed.

166. *Supplemental Response* of plaintiffs to city defendants' first request for production filed. Copies mailed 8-22-78.

8-24-78

167. *Order* granting motion of applicants extension of time to file motion to proceed as amici curiae filed. Contie, J.

168. *Motion* of applicants for leave to proceed amici curiae with attachments filed.

169. *Order* that individual physicians and health professionals named in attached list have leave to proceed as amici curiae and join with NARAL and APHA in filing brief on behalf of plaintiffs filed. Contie, J. Copies mailed 8-25-78.

170. *Order* denying motions of pltf. and deft. for partial summary judgment filed. Contie, J. Copies mailed 8-25-78.

8-28-78

171. *Deposition* of Marvin Weinberger taken on 8-2-78 at 3:17 p.m. with attachments filed. Fees $____.

172. *Deposition* of Ray Kapper, President of Akron City Council taken 8-2-78 at 9:40 a.m. filed. Fees $_____. (With attachments).

173. *Deposition* of Alan G. Segedy taken on 8-2-78 at 12:44 p.m. with attachments filed. Fees $_____.

174. *Deposition* of Robert Goehler taken on 8-3-78 at 9:50 a.m. with attachments filed. Fees $____.

8-29-78

175. *Motion* for leave to file a motion with memorandum in support filed. Copies mailed, no date.

176. *Deposition* of Roseann Doria taken on 8-10-78 at 9:15 a.m. filed. Fees $_____.

177. *Deposition* of Kathleen Gotshall taken on 8-11-78 at 9:45 a.m. filed. Fees $_____.

178. *Deposition* of Starlett C. Hurst taken on 8-10-78 at 3:50 a.m. filed. Fees $_____.

179. *Deposition* of Norma Goldberger taken on 8-10-78 at 11:31 filed. Fees $_____.

180. *Deposition* of Robert T. Bliss, M.D. taken on 8-15-78 at 3:34 p.m. filed. Fees $_____.

181. *Deposition* of Rein Siiner, M.D. taken on 8-8-78 at 11:05 a.m. filed. Fees $_____.

182. *Memorandum* in support of motion to dismiss Dr. Robert Bliss, Akron Center for Reproductive Health, Inc., Akron Women's Clinic Inc., and WomenCare, Inc. (3 copies) filed. All copies ***under seal.***

8-30-78

183. *Order* that complete trial briefs, stipulation (if any), 2 copies of all exhibits, copy of what counsel believes are issues, proposed findings of fact, conclusions of law, list of proposed witnesses are to be submitted to the Court forthwith. Further, exhibits to be marked before trial, pltf. using numbers, and deft. using letters filed. Copies mailed 8-30-78.

184. *Order* denying motion of defts. to dismiss filed. Copies mailed 8-30-78.

8-31-78

185. *Motion* of deft.-intervenors for leave to permit James Bopp, Jr., to appear as counsel with attachment filed. Copies mailed 8-31-78. 8-31-78 End. Order granting motion. Contie, J.

9-1-78

186. *Trial Brief* of intervenors filed. (With attachments). No service.

187. *Index* to deft.'s exhibits filed. No service.

188. *List* of defendant-intervenors of basic issues to be determined in this action filed. No service.

189. *Witnesses* to be called by defendant-intervenors ***under seal*** filed.

190. *Findings* of fact of defendant-intervenors filed. No service.

191. *Proposed Conclusions* of law of defendant-intervenors filed. No service.

192. *Index* of defendant's exhibits filed. No service. (***under seal***).

193. *Witnesses* to be called by defendant filed. No service.

194. *Pretrial Brief* of defts. City of Akron, John S. Ballard, Dr. C. Wm. Keck and Peter Oldham filed. No service.

195. *Statement* of issues of defts. City of Akron, John S. Ballard, Dr. C. Wm. Keck & Peter Oldham filed. No service.

196. *Trial Brief* of plaintiffs filed. No service.

197. *Supplemental Responses* of plaintiffs to city defendants' request for admissions filed. Copies mailed 9-1-78.

9-5-78

198. *Proposed Findings* of facts and conclusions of law of Defts. Ballard, Keck and Oldham filed.

199. *Return* re (7) Subpoena to Produce Document or Object filed. Served Dr. Gary Benfield on 9-5-78, Nancy L. Walker on 9-__-78, Betty Ragan on 9-2-78, John S. Ballard, Mayor of Akron, on 9-2-78, Dr. Charles Bowen on 9-1-78, Dr. C. William Keck on 9-2-78, and Joyce Bender on 9-2-78. Fees $_____.

200. *Return* re Civil Subpoenas (3) filed. Served Reginald Brooks on 9-1-78, Alan Segedy, and Ray Kapper on 9-1-78. Fees $_____.

9-13-78

201. *Deposition* of Francine Lucas taken on 8-8-78 at 9:15 a.m. filed.

202. *Deposition* of Dr. A. taken on 8-9-78 at 10:43 a.m. filed. ***Under seal.***

203. *Deposition* of Dr. B. taken on 8-17-78 at 11:08 a.m. filed. ***Under seal.***

9-19-78

204. *Order* finding motion of Drs. John Dettling & Wm. Cook to quash subpoenas filed by plaintiffs directing production of certain hospital records to be moot filed. Contie, J.

9-20-78

205. *Minutes* of proceedings filed. Contie, J. Kreitzburg, Tedrahn, Purser, Thompson, r. Tried by

the Court on Sept. 5, 6, 7, 8, 11, 12, 13, 14, 15, 18, 19, 20, 1978. Total trial time: 47 hrs., 10 min.

9-21-78

206. *Motion* for leave to proceed as amici curiae filed. Copies mailed 9-21-78.

9-25-78

207. *Order* that the physicians and health professionals named in list submitted to the Court may join in filing brief on behalf of plaintiffs filed. Contie, J.

9-26-78

208. *Marshal's Return* re Civil Subpoena filed. Served Francine Lucas on 9-13-78. Fees $2.48.

209. *Marshal's Return* re (6) Civil Subpoenas filed. Served Dr. A. on 9-12-78, As To Dr. B, RTUX. Served Robin Ratcliff on 9-13-78, Starlett Hurst on 9-11-78, Dr. Rein Siiner on 9-11-78, and Kathleen Gottshall on 9-11-78. Fees $12.85.

210. *Marshal's Return* re Subpoena to Produce Documents of objects filed. Served Norma Goldberger on 9-12-78. Fees $2.48.

9-27-78

211. *Marshal's Return* re Civil Subpoena filed. Served Kathryn Bajo on 9-__-78. Fees $3.00.

10-11-78

212. *Transcript* of proceedings before Judge Contie 9-5-78 (Vol. 1) filed. Purser, r.

213. *Transcript* of proceedings before Judge Contie 9-6-78 (Vol. 2) filed. Purser, r.

214. *Transcript* of proceedings before Judge Contie 9-7-78 (Vol. 3) filed. Tedrahn, r.

215. *Transcript* of proceedings before Judge Contie 9-8-78 at 9:15 a.m. (Vol. 4) filed. Tedrahn, r.

216. *Transcript* of proceedings before Judge Contie 9-11-78 (Vol. 5) filed. Kreitzburg, r.

217. *Transcript* of proceedings before Judge Contie 9-12-78 at 9 a.m. (Vol. 6) filed. Kreitzburg, r.

218. *Transcript* of proceedings before Judge Contie 9-13-78 (Vol. 7) filed. Prather, r.

219. *Transcript* of proceedings before Judge Contie 9-14-78 (Vol. 8) filed. Prather, r.

220. *Transcript* of proceedings before Judge Contie 9-15-78 at 9 a.m. (Vol. 9) filed. Christy, r.

221. *Transcript* of proceedings before Judge Contie 9-15-78 at 9 a.m. (Vol. 10) filed. Christy, r.

10-24-78

222. *Motion* of defts. City of Akron, John Ballard, Dr. C. Wm. Keck, & Peter Oldham & Deft.-Intervenors Francois Seguin, M.D. & Patricia K. Black for extension of time of 14 days to file briefs, after receipt of final portion of transcript filed (With Memorandum in support). Copies mailed Oct. 1978 (Day omitted).

10-25-78

223. *Order* vacating previously established briefing scheduled. Post-trial briefs of all parties shall be due on 11-15-78. Any reply briefs the parties deem appropriate shall be due by 11-30-78 filed. Contie, j. Copies mailed 10-25-78.

11-13-78

224. *Brief* of defts. City of Akron, John S. Ballard, Dr. Keck & Peter Oldham filed. Copies mailed 11-13-78.

11-15-78

225. *Post-trial Brief* of plaintiffs filed. (With attachment). Copies delivered 11-15-78.

226. *Brief* of deft.-intervenors as parties and as Amici Curiae (Part I) with attachments filed. Copies served 11-15-78.

227. *Post-trial Brief* of defendant-intervenors (Part II) filed. Copy hand delivered 11-15-78.

11-27-78

228. *Minutes* of proceedings filed. Contie, J. Supplee, r. Heard by the Court Nov. 27, 1978. Total trial time: 5 hrs. Preliminary injunction hearing.

11-29-78

229. *Reply Brief* of defendants City of Akron, John S. Ballard, Dr. C. Wm. Keck & Peter Oldham filed. Copies mailed 11-29-78.

230. *Response* of defendant-intervenors to plaintiffs' post-trial brief filed. Copies mailed 11-29-78.

11-30-78

231. *Post-trial Reply Brief* of plaintiffs (copy) filed. (With attachments). Copies mailed 11-29-78.

12-7-78

232. *Brief* of Amici Curiae in support of plaintiffs with attachments filed. (Copy). Copies mailed (Date omitted).

1-31-79

233. *Motion* of deft. & deft.-intervenors for leave to file Briefs filed. Copies mailed 1-31-79.

2-1-79

234. *Order* granting motion of defts. & deft.-intervenors that all parties file post-trial briefs on

impact, if any, of Supreme Court's decision in *Colautti* by 3-5-79. Any reply briefs by 3-19-79 filed. Contie, J. Copies mailed 2-1-79.

3-1-79

235. *Supplemental Brief* of deft. City of Akron filed. Copies mailed 3-1-79.

3-5-79

236. *Brief* of Defendant-Intervenors re *Colautti v. Franklin* filed. Copies mailed 3-5-79.

3-7-79

237. *Supplementary Brief* of plaintiffs concerning *Colautti v. Franklin* filed. Copies mailed 3-5-79.

3-19-79

238. *Answer Brief* of defendant, City of Akron filed. Copy mailed 3-__-79.

239. *Reply Brief* of deft.-intervenors to supplementary brief concerning *Colautti v. Franklin* of plaintiffs filed. Copies mailed 3-19-79.

3-30-79

240. *Entry* of appearance of Gordon J. Beggs on behalf of pltfs. in substitution for Wayne G. Hawley filed. Copy mailed 3-29-79.

5-7-79

241. *Letter* from Stephan Landsman to the Hon. Leroy Contie, Jr. bringing two recent decisions to attention of the Court filed.

5-24-79

242. *Supplemental Brief* of deft.-intervenors filed. Copy served 5-23-79.

7-10-79

243. *Motion* of deft.-intervenors Seguin & Black for leave to file brief as to *Bellotti v. Baird* filed. Copies mailed 7-10-79.

244. *Order* granting motion of deft.-intervenors for leave to file briefs on Supreme Court's decision in *Bellotti v. Baird* by 7-23-79 filed. Contie, J. Copies mailed 7-11-79.

7-23-79

245. *Brief* of deft.-intervenors re *Bellotti v. Baird* filed. Copies mailed 7-23-79.

246. *Suppemental Brief* of deft. filed. Copies mailed 7-23-79.

7-25-79

247. *Supplementary Brief* of plaintiff re *Bellotti v. Baird* filed. Copy mailed 7-23-79.

8-6-79

248. *Reply* of deft.-intervenor to pltf.'s supplementary brief re *Bellotti v. Baird* filed. Copies mailed 8-2-79.

8-15-79

249. *Response* of plaintiffs to Intervenors' Second Brief concerning *Bellotti v. Baird* filed. Copies mailed 8-14-79.

8-22-79

250. *Memorandum, Opinion and Order* filed. Contie, J. Copies hand delivered 8-22-79.

251. *Judgment Entry* filed. Contie, J. Copies hand delivered 8-22-79.

8-31-79

252. *Motion* of plaintiffs for new trial or in alternative, to alter or amend the judgment with memorandum in support filed. Copy mailed 8-31-79.

9-7-79

253. *Notice* of appeal of defts. Francois Seguin, M.D. & Patricia K. Black—appellants filed. No service. Copies mailed by the Clerk 9-10-79.

9-12-79

254. *Memorandum* of deft.-intervenors in opposition to pltfs.' motion for new trial or in alternative to alter or amend judgment filed. Copies mailed 9-12-79.

9-17-79

255. *Memorandum* of defts. in opposition to motion for new trial or to alter or amend judgment filed. Copies mailed 9-15-79.

9-18-79

256. *Motion* of plaintiffs for Order that record be retained in District Court with memorandum in support filed. Copies mailed 9-17-79.

9-17-79

257. *Certificate* re transcript of proceedings by deft.-appellants filed. Copies mailed 9-17-79.

9-20-79

258. *Order* granting motion of plaintiffs for Order that record be retained in the District Court filed. Contie, J. Copies mailed 9-20-79.

9-19-79

259. *Reply* of plaintiffs to intervenors' memorandum in opposition to plaintiffs' motion for new trial filed. Copies mailed 9-19-79.

260. *Notice* of appeal of pltfs.-appellants filed. Notice mailed by Clerk 9-21-79.

9-28-79

261. *Order* striking Notice of appeal filed on 9-19-79 filed. Contie, J. Copies mailed 9-28-79.

10-3-79

262. *Rejoinder* of deft.-intervenors to pltfs.' reply to intervenors' memorandum in opposition to pltfs.' motion for new trial filed. Copies mailed 10-2-79.

10-4-79

263. *Order* that plaintiffs' Motion for new trial or in the alternative to alter or amend the judgment is granted in part and denied in part filed. Contie, J. Copies mailed 10-5-79.

10-15-79

264. *Motion* of plaintiffs for award of attorneys' fees with memorandum in support and attachment—$61,125.00 filed. Copies mailed 10-15-79.

265. *Bill* of costs of plaintiffs—$4,079.35 filed. Copies mailed 10-15-79. Costs of $4,079.35 taxed by Cleark 10-30-79. Copies mailed 10-30-79.

10-19-79

266. *Letter* from Alan G. Segedy indicating parties consent to extension of time for filing responsive brief to pltfs.' motion for attys.' fees filed.

267. *Letter* from Gordon J. Beggs for release of $100.00 TRO bond filed.

268. *Order* granting deft.-intervenors leave to file written statements of reasons in opposition to pltfs.' motion for award of attys.' fees to 11-15-79 filed. Contie, J. Copies mailed 10-19-79.

269. *Order* that Clerk release $100.00 cash TRO Bond to Stephan A. Landsman filed. Contie, J. Original and copy mailed 10-19-79.

10-22-79

270. *Acknowledgment* of receipt of Notices of Appeal by USCA for the Sixth Circuit filed. Case Nos. 79-3650 and 79-3651 filed 10-22-79.

271. *Order* granting deft.-intervenors leave to 11-5-79 to serve & file written statements of reasons in opposition to pltfs.' motion for award of attorneys' fees filed. Contie, J. Copies mailed _____.

10-25-79

272. *Notice* of change of address of attorney James L. Bickett, atty. for defts. filed. Copies mailed Oct. 1979 (Day omitted).

273. *Memorandum* of defts. in opposition to pltf.'s motion for atty.'s fees filed. Copies mailed Oct. 1979 (day omitted).

10-29-79

274. *Motion* of defts. City of Akron, John S. Ballard, Dr. Keck & Peter O. Oldham for attorney's fees & costs of $28,508.99 with memorandum and attachments in support filed. Copies mailed 10-29-79.

275. *Order* amending Order of 10-19-79 releasing $100.00 TRO bond filed. Contie, J. Original and copy mailed 10-29-79.

10-30-79

276. *Notice* of appeal of intervening defts.-appellants filed. Notice mailed by the Clerk 10-30-79.

10-31-79

277. *Affidavit* of Wayne Hawley filed. No service.

278. *Affidavit* of Patricia S. Roberts filed. No service.

11-1-79

279. *Order* granting pltf.'s leave to consolidate their Reply to defts.' memorandum in opposition to pltfs.' motion for atty.'s fees with their reply to deft.-intervenors' memorandum on same subject to be filed within 10 days of service of deft.-intervenors' memorandum upon pltfs. filed. Contie, J. Copies mailed 11-1-79.

11-5-79

280. *Affidavit* of Ellen Leitzer filed. No service.

281. *Order* granting pltfs. leave to consolidate their Reply to defts.' Motion for atty.'s fees with their Reply to deft.-intervenors' memorandum on subject of pltfs.' motion for atty.'s fees to be filed within 10 days of service of deft.-intervenors' memorandum upon pltfs. filed. Contie, J. Copies mailed 11-6-79.

11-7-79

282. *Certificate* of deft.-intervenors re transcript of proceedings filed. Copies mailed 11-7-79.

11-9-79

283. *Letter* (copy) from Alan G. Segedy to Stephan Landsman re appeal filed.

11-13-79

Certified Original Pleadings mailed to USCA for the Sixth Circuit.

284. *Notice* of Appeal of plaintiffs-appellants filed. Copy of this pleading with copy of docket sheet mailed to USCA for the Sixth Circuit 11-13-79.

11-14-79

285. *Motion* of deft. City of Akron for extension of time for filing Notice of appeal filed. Copies mailed November, 1979 (day omitted).

11-15-79

Omnibus Response of pltfs.' concerning atty.'s fees and costs filed. Copies mailed 11-15-79.

11-20-79

286. *Brief* of deft. City of Akron in support of its motion to extend time for filing Notice of Appeal filed. Copy mailed 11-19-79.

287. *Affidavit* of Vic Dandrea filed.

11-21-79

288. *Designation* of plaintiffs that no further transcript materials are to be ordered from the reporter and entire transcript is to be part of record filed. Copies mailed 11-21-79.

11-28-79

Motion of deft.-intervenors for leave to filed Reply to pltfs.' omnibus response concerning atty.'s fees & costs with attachments filed. Copies mailed 11-27-79. 11-28-79 Endorsed Order granting motion. Contie, J. Copies mailed 11-28-79.

12-4-79

289. *Order* granting motion of deft. City of Akron for extension of time to file Notice of appeal filed. Contie, J. Copies mailed 12-5-79.

290. *Notice* of appeal of deft.-appellant City of Akron filed. Copies mailed Nov. 1979 (Day omitted). Copies mailed by Clerk to all counsel 12-11-79.

12-11-79

291. *Certificate* re transcript of proceedings & designation of record by defts. City of Akron, John S. Ballard, Dr. Wm. Keck & Peter Oldham filed. Copies mailed 12-12-79.

Supplemental Pleadings 285-291 mailed to USCA for th Sixth Circuit.

MOTION OF PLAINTIFF TO PRESENT AFFIDAVIT OF PLAINTIFF DR. DOE IN A SEALED ENVELOPE WITH MEMORANDUM IN SUPPORT AND AN AFFIDAVIT OF DR. DOE

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF OHIO
Eastern Division

Case No. C78-155A

[Filed: April 19, 1978]

DR. DOE, *ET AL.*,
Plaintiffs

v.

CITY OF AKRON, *ET AL.*,
Defendants

Before Judge Contie

MOTION TO PRESENT AFFIDAVIT OF PLAINTIFF DOE IN A SEALED ENVELOPE

Plaintiffs hereby move the Court that due to the sensitive nature of the matters contained in the accompanying complaint the true name affidavit of plaintiff Dr. Doe (a pseudonym), presented to the Court concurrently herewith, be held by the Court in a sealed envelope to preserve the anonymity of Dr. Doe and that Dr. Doe be allowed to continue in this case under this pseudonym.

Plaintiffs attach hereto in support of this motion a memorandum of law and an affidavit by Dr. Doe.

Respectfully submitted,

/s/ Stephan A. Landsman
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Of Counsel:

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Attorneys for Plaintiffs
on behalf of the American
Civil Liberties Union of Ohio
Foundation, Inc.

MEMORANDUM IN SUPPORT OF MOTION TO PRESENT AFFIDAVIT OF PLAINTIFF DOE IN A SEALED ENVELOPE

Because of the sensitive and controversial nature of the matters involved in this case and because of the

severe personal, professional and economic consequences which revealing his/her identity would cause Dr. Doe, plaintiff Doe should be able to remain in the case under a pseudonym. See *Roe v. Wade*, 410 U.S. 113, 124 (1973); *Coe v. Gerstein*, 376 F. Supp. 695, 696 (S.D. Fla. 1973).

Respectfully submitted,

/s/ Stephan A. Landsman
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Attorneys for Plaintiffs
on behalf of the American
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Foundation, Inc.

SEALED AFFIDAVIT OF DR. DOE

I, Doctor Doe (a pseudonym), being duly sworn, depose and say:

1. I request the Court to allow me to file an affidavit, revealing my true identity, in a sealed envelope and to continue in this suit under the pseudonym of Dr. Doe. I make this request because of the severe personal, professional and economic consequences which revealing my identity would cause, as set forth in detail for the Court in the sealed affidavit.

2. I am a physician licensed by the State of Ohio, and am a board-certified specialist in obstetrics and gynecology.

3. I have in the past and intend in the future to perform abortions within the City of Akron.

4. I fear that I will be prosecuted if I perform an abortion on or after May 1, 1978, without complying with the provisions of Ordinance No. 160-78.

5. I will lose income because of Ordinance No. 160-78, because the ordinance will deter my patients from seeking abortions within the City of Akron.

6. I wish to assert my rights as a physician, the rights of my fellow physicians, and the rights of the patients whom we will serve against interference from Ordinance No. 160-78.

7. Ordinance No. 160-78 interferes with the following rights of myself and my patients:

a. Section 1870.03 (Abortion in Hospital) is a regulation of the second trimester procedure, which, in the case of early second trimester procedures, is not reasonably related to protection of maternal health, and which therefore impermissibly interferes with my

patient's privacy and my right to practice medicine. I may in the future perform an early second trimester procedure outside of a hospital, if permitted by law.

b. Section 1870.04 (Abortion after Viability) establishes a presumption of viability without any reasonable relationship to reality; may require a procedure more dangerous to the pregnant woman where that presumption exists, with no reasonable benefit to the potential for life; and requires a second physician where not medically necessary; in fact, a single obstetrician handles premature birth of a child at any stage of the pregnancy. This section endangers the woman's life and interferes with the physician's right to practice. I may in the future, if requested, perform an abortion for a woman 22 weeks pregnant.

c. Section 1870.05 (Notice and Consent) would require me to violate my duty to maintain my patients' confidentiality by notifying third parties. I presently determine, for any patient of any age, whether she is mature and competent enough to give knowing, voluntary consent to the medical procedure. If I determine that she is, I give her all the information which is necessary for her consent to be informed, including the nature of the procedure, its risks and benefits, and the alternatives. This section interferes with my patients' right of privacy, the physician-patient relationship, and my right to practice medicine.

d. Section 1870.06 (Informed Consent) interferes with my obligation to tailor the information which I give a patient to her particular best interest. The statement that "the unborn child is a human life from the moment of conception" is not scientifically sound. I consider it a religious statement, and object to the City's requiring me or any physician to give it, or our

patients to hear it. The survival of a fetus born or aborted at 22 weeks gestation is extremely unlikely and the usual and customary medical treatment of a case at that stage in the pregnancy is that of a spontaneous miscarriage, for which no attempt at resuscitation is made. To give such inaccurate advice about viability is not only confusing, because usually irrelevant, but medically irresponsible. Abortion is not a major surgical procedure. To give such information is also irresponsible. The entire section interferes with the patients' right to privacy, with the physician-patient relationship, and with the physician's right to practice medicine.

e. Section 1870.07 (Waiting Period) would have caused unnecessary anxiety for some women for whom I have performed abortions, because these women had already made a careful, informed decision to terminate their pregnancies and neither desired nor required any waiting. I will suggest a waiting period before any surgical procedure when the patient manifests such ambivalence about her decision that she seems not truly to have decided. I consider this section an unwarranted invasion of patients' right to treatment, as well as an interference with my right to practice.

f. Section 1870.09 (Inspection) could endanger the health of my patients. I perform abortions and other minor surgical procedures, in facilities which are not open to the public, so that intrusions of strangers are definitely not expected. Such intrusions during any surgical procedure could endanger a patient's health. I also object to complete access by inspectors to the private medical records of all my patients. I consider this section an unwarranted invasion of my patient's right to privacy.

g. Section 1870.10 (Reporting) duplicates a report which I have executed for each abortion which I have performed, and which report I send to the State of Ohio. I object to this duplication as an unnecessary burden on the abortion procedure.

I say nothing further.

/s/ Dr. Doe
(a pseudonym)

[SEAL]
STATE OF OHIO:
SUMMIT COUNTY:

Dr. Doe personally appeared before me this 14th day of April, 1978 and upon oath states that the foregoing is true to the best of his knowledge.

/s/ Patricia A. Vance
Notary Public

MOTION OF PLAINTIFFS TO PRESENT AFFIDAVIT OF PLAINTIFF LOE IN A SEALED ENVELOPE WITH MEMORANDUM IN SUPPORT AND AN AFFIDAVIT OF LINDA LOE

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF OHIO
Eastern Division

Case No. C78-155A

[Filed: May 8, 1978]

LINDA LOE, *ET AL.*,
Plaintiffs

v.

CITY OF AKRON, *ET AL.*,
Defendants

Before Judge Contie

MOTION TO PRESENT AFFIDAVIT OF PLAINTIFF LOE IN A SEALED ENVELOPE

Plaintiffs hereby move the Court that due to the sensitive nature of the matters contained in this action the true name affidavit of plaintiff Linda Loe (a pseudonym), presented to the Court concurrently herewith, be held by the Court in a sealed envelope to preserve the anonymity of Linda Loe and that Linda Loe be allowed to continue in this case under this pseudonym. Plaintiffs

attach hereto in support of this motion a memorandum of law and an affidavit of Linda Loe.

Respectfully submitted,

/s/ Stephan A. Landsman
Cleveland-Marshall College of Law
Cleveland State University
Cleveland, Ohio 44115
(216) 687-2529

Of Counsel:

Janet Benshoof
American Civil Liberties Union
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Attorneys for Plaintiffs
on behalf of the American
Civil Liberties Union of Ohio
Foundation, Inc.

MEMORANDUM IN SUPPORT OF MOTION TO PRESENT AFFIDAVIT OF PLAINTIFF LOE IN A SEALED ENVELOPE

Because of the sensitive and personal nature of the matters involved in this case and because of the severe psychological and emotional consequences which reveal-

ing her identity would cause her, plaintiff Loe should be able to remain in the case under a pseudonum.

Courts have routinely permitted pregnant women challenging abortion regulations to proceed under pseudonyms. See *Roe v. Wade*, 410 U.S. 113, 124 (1973); *Doe v. Bolton*, 410 U.S. 179, 187 (1973); *Coe v. Gerstein*, 376 F. Supp. 695, 696 (S.D. Fla. 1973); and *Lady Jane v. Maher*, 420 F. Supp. 318 (D. Conn. 1976).

The earlier decision in *Roe v. State of New York*, 49 F.R.D. 279 (S.D.N.Y. 1970), is distinguishable because that case did not involve private sexual matters and because the court there emphasized its desire to have "at least one plaintiff" identified by his true name. Three of the four plaintiffs here do reveal their true name.

For these reasons plaintiff Loe should be permitted to protect her intimate privacy by proceeding under a pseudonum.

Respectfully submitted,

(By) /s/ Wayne G. Hawley

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Foundation, Inc.

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF OHIO
Eastern Division

Case No. C78-155A

LINDA LOE, *ET AL.*,
Plaintiffs

v.

CITY OF AKRON, *ET AL.*,
Defendants

STATE OF OHIO
COUNTY OF SUMMIT

Before Judge Contie

AFFIDAVIT OF LINDA LOE
(a pseudonym)

I, Linda Loe (a pseudonym), being duly sworn, depose and say:

1. I am a woman with children residing in the City of Akron. I am presently in the tenth week of pregnancy and I desire to terminate my pregnancy by an abortion. I intend to do so within the City of Akron.

2. I wish to be a plaintiff in this lawsuit to assert my constitutional rights, and the rights of all women, pregnant now and in the future, who wish to terminate their pregnancies within the City of Akron.

3. I have read the First Amended Complaint. The facts therein are true and accurate to the best of my knowledge.

4. I request the Court to allow me to file an affidavit, revealing my true identity, in a sealed envelope and to continue in this suit under the pseudonym of Linda Loe. I make this request because of the sensitive, private nature of my decision and because of the humiliation which I would feel if my identity were publicly known.

I say nothing further.

/s/ Linda Loe
(a pseudonym)

Sworn to and subscribed before me this 3rd day of May, 1978 at Akron, Ohio.

/s/ Wayne G. Hawley
Notary Public
(My commission has no expiration date.)

CERTIFICATE OF SERVICE

A copy of the foregoing Motion to Present Affidavit of Plaintiff Loe in a Sealed Envelope was mailed this 3rd

day of May, 1978 to James L. Bickett, 304 Municipal Building, Akron, Ohio 44308 and to David G. Umbaugh, 40 East Mill Street (at Main), Akron, Ohio 44308.

/s/ Wayne G. Hawley

SEALED AFFIDAVIT OF DR. DOE TO PROCEED BY PSEUDONYM WITH DELETIONS

[Logged: April 13, 1978]

Cleveland State University
Cleveland-Marshall College of Law
Cleveland, Ohio 44115

SEALED TRUE NAME AFFIDAVIT OF DR. DOE

FOR THE COURT'S EYES *ONLY*

I, being duly sworn, depose and say:

1. I am a physician duly licensed by the State of Ohio, and am a board-certified specialist in obstetrics and gynecology.

2. I am medical director of Plaintiff, . I perform now, and intend to perform in the future, within the City of Akron, abortion procedures by the suction curettage method for women on an out-patient basis through the twelfth week of gestation.

3. I wish to appear as a Plaintiff in this litigation, in order to assert my rights, the rights of my fellow physicians, and the rights of our patients, but will only do so if I may appear under the assumed name of Dr. Doe.

4. Despite my position at , my limited involvement with abortions is not widely known. If I appear openly as a Plaintiff in this lawsuit, I am certain that the wide publicity accompanying that participation will cause me to be labelled the "Akron abortionist" by large parts of the public. I fear the following consequences on that publicity and that labelling:

a. A loss of reputation and a loss of income with to my primary role as an obstetrician and gynecologist in an active private practice. I base these expected losses in part on an experience of a colleague who lost a patient when the patient learned that the physician on occasion performed first trimester abortions.

b. A significant interference with my ability to continue in the development of a newly established education program at
College of Medicine, where I am on the faculty as a clinical assistant professor. That interference would occur because of the sensitivity of such government-funded programs to controversy.

c. Physical and psychological harm to my children, ages , and . Besides psychological harm coming, for example, from taunts from other children, I have recently developed a real fear about the possibility of physical harm, particularly given the high level of emotion in the Akron area.

d. Fear for my own personal safety. I have already been the victim of one unprovoked physical attack because of my presently little known involvement with abortions.

I am the real party in this action and assume the name of Dr. Doe in order to preserve my anonymity.

I say nothing further.

[SEAL]

STATE OF OHIO:
SUMMIT COUNTY:

personally appeared before me this 14th day of April, 1978 and upon oath states that the foregoing is true to the best of his knowledge.

/s/ Patricia A. Vance
Notary Public

SEALED AFFIDAVIT OF LINDA LOE TO PROCEED BY PSEUDONYM WITH DELETIONS

[Logged: May 3, 1978]

American Civil Liberties Union of Ohio

SEALED **TRUE NAME AFFIDAVIT OF LINDA LOE**

FOR THE COURT'S EYES *ONLY*

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF OHIO
Eastern Division

Case No. C78-155A

LINDA LOE, *ET AL.*,
Plaintiffs

v.

CITY OF AKRON, *ET AL.*,
Defendants

STATE OF OHIO
COUNTY OF SUMMIT

Before Judge Contie

AFFIDAVIT OF LINDA LOE

I, being duly sworn, depose and say:

1. I am the woman identified by the pseudonym Linda Loe.

2. I reside at , Akron, Ohio. I am twenty-three years of age. I am the mother of children. I am unmarried. I support myself and my children with money from Aid to Families with Dependent Children.

3. I am presently in the tenth week of pregnancy. I desire to terminate this pregnancy because I do not have the money, nor the physical or emotional strength, to raise any additional children. I presently have an appointment to have my pregnancy terminated at Clinic on , May , 1978.

4. I wish to be a plaintiff in this lawsuit to assert my constitutional rights, and the rights of all women, pregnant now and in the future, who wish to terminate their pregnancies within the City of Akron.

5. I wish to proceed anonymously because of the humiliation which revealing my identity would cause me. If my name were in the newspapers, I would be extremely upset, because I do not want anyone to know about my private sexual matters. My parents, who live in Akron, would also be very upset if they learned that I was having an abortion. They are extremely religious, and have often told me that they do not approve of abortion, because of their religious and personal views.

I say nothing further.

Sworn to and subscribed before me this 3rd day of May, 1978 at Akron, Ohio.

/s/ Wayne G. Hawley
Notary Public
My commission has no expiration date.

ORDER DENYING MOTION OF PLAINTIFF TO ALLOW DR. DOE TO PROCEED UNDER SUCH PSEUDONYM

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF OHIO
Eastern Division

Case No. C78-155A

[Filed: April 27, 1978]

DR. DOE, *ET AL.*,
Plaintiffs

v.

CITY OF AKRON, *ET AL.*,
Defendants

Before Judge Contie

ORDER

Plaintiffs have moved the Court to retain the true name affidavit of plaintiff Dr. Doe, a pseudonym, under seal and to allow Dr. Doe to proceed in this action under such pseudonym. Upon consideration and for the reasons set forth below, the instant motion shall be denied.

This action was initiated to test the constitutionality of Ordinance No. 160-1978 which amended and supplemented the Codified Ordinances of the City of Akron 1975, by the amendment of Chapter 1870, entitled "Regulation of Abortions." The plaintiffs are a doctor

under the fictitious name of Dr. Doe and three outpatient clinics. The named defendants consist of the City of Akron and three of its officials alleged to be responsible for the administration and enforcement of Ordinance No. 160-1978. Declaratory and injunctive relief is sought. The jurisdiction of the Court is invoked under 28 U.S.C. §§ 1331 and 1343.

In the complaint herein, Dr. Doe is described as a physician licensed to practice medicine in the State of Ohio, specializing in obstetrics and gynecology, who now performs, and in the future intends to perform, abortions within the City of Akron. Dr. Doe seeks to bring this action as a class action on his own behalf and on behalf of all physicians similarly situated.

By the instant motion, Dr. Doe raises the issue of his right to appear and proceed anonymously as a party plaintiff and potential class representative. In support of the motion, Dr. Doe states in an affidavit that revelation of his identity would cause severe personal, professional, and economic consequences.

No provision in federal law according a plaintiff the right to prosecute an action under a fictitious name has come to the attention of the Court. Rather, Rule 10(a), Federal Rules of Civil Procedure, provides, in pertinent part, that the title of the action in the complaint shall include the names of all parties. Despite said provision, individuals have been permitted in certain cases to sue under fictitious names. However, such is clearly an exception and privilege.

Lawsuits are matters of public record and the public has a recognized and valid interest in knowing the facts, including the identity of the parties. This is especially true in a lawsuit, such as the case at bar, wherein an ordinance or local law assertedly affecting the rights of

residents of a community is subject to a constitutional challenge. Thus as a matter of public policy, the Court deems it inappropriate to conceal the identity of parties except in the most unusual case. Such view has previously been expressed as follows:

> The privilege of using fictitious names in actions should be granted only in rare cases where the nature of the issue litigated and the interest of the parties demand it and no harm can be done to the public interest.

Roe v. State of New York, 49 F.R.D. 279, 282 (S.D. N.Y. 1970), quoting, *Buxton v. Ullman*, 147 Conn. 48, 156 A.2d 508 (1959).

Under the circumstances herein presented, the Court finds that as to Dr. Doe this is not such an unusual or exceptional case. His private or personal matters are not in issue or subject to scrutiny in this action. Rather, this action relates solely to professional and economic concerns. Essentially, Dr. Doe seeks a determination of the legality of freely chosen future conduct in the exercise of his profession. In view thereof, the Court finds no sufficient reason to disregard the public interest in a policy of full disclosure. Thus, the Court shall not permit Dr. Doe to proceed anonymously in this action.

Said conclusion finds additional support in the fact that Dr. Doe seeks to bring this action as a class action. It is well established that a determination of the adequacy of the proposed class representative is necessary to class certification. Thus the identity of Dr. Doe is relevant and material to the further prosecution of this action in its present posture.

Accordingly, the instant motion is hereby denied and the true name and address of Dr. Doe shall be designated in the caption of the complaint if he desires to proceed

in this action. Further, plaintiffs are hereby granted five (5) days leave from the date of this Order to amend their complaint in accordance herewith.

IT IS SO ORDERED.

/s/ Leroy J. Contie, Jr.
U.S. District Judge

ORDER DENYING MOTION OF PLAINTIFF TO ALLOW LINDA LOE TO PROCEED UNDER SUCH PSEUDONYM

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF OHIO
Eastern Division

Case No. C78-155A

[Filed: May 3, 1978]

LINDA LOE, *ETC., ET AL.*,
Plaintiffs

v.

CITY OF AKRON, *ET AL.*,
Defendants

Before Judge Contie

ORDER

Plaintiffs have filed an amended complaint in this action. Upon consideration and for the reasons stated below, said complaint shall be stricken.

In their amended complaint, plaintiffs have omitted Dr. Doe and substituted Linda Loe for him as a party plaintiff. Such is a pseudonym and the allegations of said complaint describe plaintiff Loe as a pregnant woman who is presently seeking an abortion in the City of Akron, Ohio. She assertedly seeks to bring this action in her own behalf and on behalf of a class which includes

all women who are now or may in the future become pregnant and seek an abortion in Akron.

At the hearing, held April 27, 1978, on plaintiffs' motion for a temporary restraining order, the Court unequivocably stated that no parties shall be permitted to proceed anonymously in the within action. In view thereof and of the Court's Order of said date, the amended complaint shall be stricken and the true name and address of Linda Loe shall be designated in the caption of the complaint if she desires to proceed in this action. Plaintiffs shall be granted leave to amend their complaint on or before May 8, 1978 at 9:00 a.m.

Should plaintiffs' second amended complaint assert class allegations, they shall move for class certification on or before May 12, 1978. Defendants shall respond thereto on or before May 18, 1978. Such schedule is necessitated by the final hearing date set herein upon agreement of counsel and the delays prompted by the uncertain posture of plaintiffs' action. If further delays render the schedule more burdensome, the Court may consider other appropriate action.

Accordingly, the amended complaint is hereby stricken, and the true name and address of Linda Loe shall be designated in the caption of the complaint if she desires to proceed in this action. Plaintiffs are hereby granted leave to amend their complaint in accordance herewith on or before May 8, 1978 at 9:00 a.m. No further amendments shall be permitted without leave of Court. Further, if plaintiffs seek to assert a class action, they shall move for class certification on or before May 12, 1978, and defendants shall respond thereto on or before May 18, 1978.

IT IS SO ORDERED.

/s/ Leroy J. Contie, Jr.
U.S. District Judge

MOTION TO RECONSIDER
WITH AFFIDAVITS OF NORMA GOLDBERGER AND KATHY GOTSHALL

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF OHIO
Eastern Division

Case No. C78-155A

[Filed: May 4, 1978]

AKRON CENTER FOR REPRODUCTIVE HEALTH, INC., *ET AL.*,
Plaintiffs

v.

CITY OF AKRON, *ET AL.*,
Defendants

Before Judge Contie

MOTION FOR RECONSIDERATION

Plaintiffs hereby move this Honorable Court to reconsider its order of May 3, 1978, striking plaintiffs' First Amended Complaint. This motion to reconsider is made for the reasons more fully set forth in the brief and affidavits attached hereto and incorporated herein by reference. Plaintiffs further move this Honorable Court to permit Linda Loe (pseudonym) to continue in this case under pseudonym pursuant to plaintiffs' previous motion with regard thereto.

Respectfully submitted,

/s/ Stephan Landsman
Cleveland-Marshall College of Law
Cleveland State University
Cleveland, Ohio 44115
(216) 687-2529

Attorney for Plaintiffs
on behalf of the American Civil Liberties Union of Ohio Foundation, Inc.

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF OHIO
Eastern Division

Case No. C78-155A

AKRON CENTER FOR REPRODUCTIVE HEALTH, INC., *ET AL.*,
Plaintiffs

v.

CITY OF AKRON, *ET AL.*,
Defendants

Before Judge Contie

BRIEF IN SUPPORT OF MOTION TO RECONSIDER

Plaintiffs bring this motion in the hope of presenting to this Court adequate reason for an order granting Linda

Loe leave to proceed by pseudonym. Plaintiffs at the outset recognize the discretionary nature of an order granting such leave. They also appreciate the strong public interest in having lawsuits prosecuted in the real names of the parties involved.

In the present action the three clinic plaintiffs appear without pseudonym. They make no request that they be in any way shielded from public scrutiny. However, Linda Loe faces a very different situation and therefore moves that this Court exercise its discretion and grant her leave to proceed by pseudonym.

Linda Loe makes her request for two reasons. First, many citizens of Akron, Ohio, have had a strong emotional reaction to the debate over the propriety of abortion. Unfortunately, the debate has sparked social strike. Manifestations of this strife have included regular public demonstrations directed against the clinic plaintiffs (see Goldberger Affidavit paragraph 2; Gotshall Affidavit paragraph 2), threatening and harassing telephone calls made to the clinic plaintiffs and their employees (see Goldberger Affidavit paragraphs 3 and 4; Gotshall Affidavit paragraph 3), threatening and harassing letters sent to the clinic plaintiffs and their employees (see Goldberger Affidavit paragraph 5; Gotshall Affidavit paragraph 4) and an act of arson directed against one of the clinic plaintiffs (see Goldberger Affidavit paragraph 6).

The clinic plaintiffs can and have taken precautions adequate to deal with these serious problems (see Goldberger Affidavit paragraph 7; Gotshall Affidavit paragraph 5). Linda Loe does not have the requisite funds or assistance to take the precautions necessary to safeguard herself or her family from threats, harassment or acts of physical violence. Should she be compelled to

make her true name and address known in this litigation there is a substantial likelihood that she or her family will suffer physical or psychic harm at the hands of the misguided minority who have already victimized the clinic plaintiffs and their employees. The real possibility of injury to Linda Loe and her family marks this action as one in which an application for leave to proceed by pseudonym may appropriately be granted without undermining the strong public interests previously discussed.

The second reason for Linda Loe's request concerns the nature of the subject matter of this action. Linda Loe's claim is such that she must make public disclosure of some of the most intimate details of her personal life. This disclosure could be extremely harmful to Linda Loe if she were to proceed in her real name. While it might be argued that this is an obligation assumed by every litigant before a United States District Court, exceptions to the real name rule have been recognized in circumstances precisely like those in the present case. In the precedent setting case of *Roe v. Wade*, 410 U.S. 113 (1973), the propriety of litigation by pseudonym in the case of a pregnant woman was sustained. The same result obtained in *Coe v. Gerstein*, 376 F. Supp. 695 (S.D. Fla. 1973), and in a number of other decisions.

Linda Loe recognizes the burden her request casts upon the Court. The request to proceed by pseudonym is not made lightly or frivolously but in the serious and earnest belief that relief is warranted under the special circumstances of this case. Plaintiffs believe that no harm will be done to the public interest if Linda Loe's request is granted. They also believe that Linda Loe's request presents separate and distinct issues from those that may arise when application is made for class action certification. For the previously enumerated reasons

plaintiffs respectfully request that this Court grant plaintiff's motion to reconsider and allow Linda Loe to proceed by pseudonym.

Respectfully submitted,

/s/ Stephan Landsman
Cleveland-Marshall College of Law
Cleveland State University
Cleveland, Ohio 44115
(216) 687-2529

Attorney for Plaitniffs
on behalf of the American Civil Liberties Union of Ohio Foundation, Inc.

CERTIFICATE OF SERVICE

A copy of the foregoing Brief In Support Of Motion To Reconsider was mailed this 4th day of May, 1978, to James L. Bickett, 304 Municipal Building, Akron, Ohio 44308, and to David G. Umbaugh, 40 E. Mill Street (at Main), Akron, Ohio 44308.

/s/ Stephan Landsman
Cleveland-Marshall College of Law
Cleveland State University
Cleveland, Ohio 44115
(216) 687-2529

Attorney for Plaintiffs
on behalf of the American Civil Liberties Union of Ohio Foundation, Inc.

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF OHIO
Eastern Division

Case No. C78-155A

AKRON CENTER FOR
REPRODUCTIVE HEALTH, INC., *ET AL.*,
Plaintiffs

v.

CITY OF AKRON, *ET AL.*,
Defendants

Before Judge Contie

AFFIDAVIT

NORMA GOLDBERGER, being duly sworn, deposes and says:

1. I am president and clinic coordinator of Akron Women's Clinic, Inc. (hereinafter AWC) an Ohio Corporation. AWC operates a family planning clinic which provides abortion services at 513 West Market Street, Akron, Ohio 44303.

2. AWC has been the target of public demonstrations on a regular basis (once per week) since its opening on December 19, 1976. The number of demonstrators has varied from 1 to approximately 30. The subject of these demonstrations has always been the propriety of abortions. On occasion the demonstrators have been rowdy and/or threatening in their behavior. They have taunted AWC patients coming into and going out of the clinic.

3. The telephones at AWC have been subject to "jamming" on a regular basis. During such "jamming" the telephone lines are repeatedly occupied by callers who will not speak or hang up.

4. At my home I received a telephone call which threatened the life of my child and linked the threat to the abortion issue.

5. AWC and I have received a number of threatening letters. These letters linked the threats to the abortion issue. One of the letters contained highly offensive anti-semitic remarks. Another of the letters contained a newspaper report describing a case of suspected arson at AWC. This letter also contained the comment "there will be more".

6. In early March of 1978 there was a fire at AWC. Special Fire Investigator Finney indicated to me his belief that this fire was arson. The fire was set in a bathroom at AWC. The fire was started by the ignition of two rolls of toilet paper. Upon information and belief the fire was arson. This fire forced the evacuation of AWC and did property damage.

7. Because of the demonstrations; threatening and "jamming" telephone calls; threatening letters and act of arson committed on AWC premises I have deemed it essential to increase security precautions including the installation of stainless steel mesh over all windows, the introduction of a burglar alarm, the introduction of smoke detectors, the positioning of a receptionist in the front room of AWC at all times, and the making of arrangements to insure the physical protection of AWC and its occupants.

NORMA GOLDBERGER

SWORN TO, BEFORE ME, this 4th day of May, 1978, at Akron, Ohio.

Notary Public

[SEAL]
STATE OF OHIO
COUNTY OF SUMMIT

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF OHIO
Eastern Division

Case No. C78-155A

AKRON CENTER FOR REPRODUCTIVE HEALTH, INC., *ET AL.*,
Plaintiffs

v.

CITY OF AKRON, *ET AL.*,
Defendants

Before Judge Contie

AFFIDAVIT

KATHY GOTSHALL, being duly sworn, deposes and says:

1. I am executive director of Akron Center for Reproductive Health, Inc. (hereinafter ACRH) an Ohio corporation. ACRH operates a family planning clinic

which provides abortion services at 839 East Market Street, Akron, Ohio 44305.

2. ACRH has been the target of public demonstrations on a regular basis (once per week) in the year since its opening. The number of demonstrators has varied from approximately 5 to 15. The subject of these demonstrations has always been the propriety of abortions.

3. Because of a number of threatening, harassing and obscene telephone calls I have had to change my home telephone number from a listed number to an unlisted number. The person or persons making these telephone calls adverted to my connection with ACRH and the abortion issue during these calls.

4. ACRH and I have received approximately five harassing letters in the last year concerning the topic of abortion. These letters have included accusations that my staff and I are "murderers."

5. Because of the demonstrations; threatening, harassing and obscene telephone calls; threatening letters; and incidents of arson against abortion clinics in Akron, Ohio and Cleveland, Ohio I have deemed it essential to increase security precautions at ACRH. Newly introduced precautions include the hiring of a security guard, the introduction of dead bolt locks, the purchase of fire extinguishers and the introduction of a burglar alarm system.

KATHY GOTSHALL

SWORN TO, BEFORE ME, this 4th day of May, 1978, at Akron, Ohio.

Notary Public

[SEAL]

STATE OF OHIO
COUNTY OF SUMMIT

ORDER DENYING MOTION OF PLAINTIFFS TO RECONSIDER

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF OHIO
Eastern Division

Case No. C78-155A

[Filed: May 5, 1978]

AKRON CENTER FOR REPRODUCTIVE HEALTH, INC., *ET AL.*,
Plaintiffs

v.

CITY OF AKRON, *ET AL.*,
Defendants

ORDER

Plaintiffs have moved the Court to reconsider its Order of May 3, 1978 striking their First Amended Complaint.

Upon consideration, the instant motion is hereby denied.

IT IS SO ORDERED.

/s/ Leroy J. Contie, Jr.
U.S. District Judge

PLAINTIFFS' FOURTH AMENDED COMPLAINT

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF OHIO
Eastern Division

Case No. C78-155A

AKRON CENTER FOR REPRODUCTIVE HEALTH, INC.
839 East Market Street
Akron, Ohio 44305

and

AKRON WOMEN'S CLINIC, INC.
513 West Market Street
Akron, Ohio 44303

and

WOMENCARE, INC.
759 West Market Street
Akron, Ohio 44303

and

DR. ROBERT BLISS
411 Oak Street
Cincinnati, Ohio

Plaintiffs

v.

CITY OF AKRON
166 South High Street
Akron, Ohio 44308

and

JOHN S. BALLARD, Mayor
166 South High Street
Akron, Ohio 44308
Individually and in His Official Capacity

and

DR. C. WILLIAM KECK
Director of Public Health
177 South Broadway
Akron, Ohio 44308
Individually and in His Official Capacity

and

PETER OLDHAM, Police Prosecutor
217 South High Street
Akron, Ohio 44308
Individually and in His Official Capacity
Defendants

Before Judge Contie

FOURTH AMENDED COMPLAINT FOR DECLARATORY, INJUNCTIVE, AND OTHER RELIEF

I. Nature of the Action

1. This is a civil rights action brought under 42 U.S.C. Section 1983 and the United States Constitution by a Physician and by three out-patient clinics which provide services and facilities for the performance of abortions in the City of Akron, asserting the rights of themselves and of their patients, against the City of Akron and certain officials responsible for the enforcement and administration of Ordinance No. 160-1978, which amended and supplemented the Codified Ordinances of the City of Akron, 1975, by the amendment of Chapter 1870,

entitled "Regulation of Abortions" (a copy of Ordinance No. 160-1978 is attached as Exhibit A to the original Complaint herein; said ordinance will hereinafter be referred to as "Chapter 1870"). Plaintiffs seek declaratory and injunctive relief. The basis of the action is that Chapter 1870 violates rights guaranteed by the First, Fourth, Fifth, Ninth and Fourteenth Amendments to the United States Constitution.

II. Jurisdiction

2. This Court has jurisdiction of this action by virtue of 28 U.S.C. Section 1343(3) and 1343(4), authorizing jurisdiction of claims brought under 42 U.S.C. Section 1983 to enforce rights guaranteed by the United States Constitution. This Court also has jurisdiction of this action pursuant to 28 U.S.C. Section 1331 as the claims arise under the United States Constitution and the matter in controversy exceeds $10,000.00, excluding costs and interest. This action also seeks declaratory judgment pursuant to 28 U.S.C. Section 2201 and 2202.

III. Parties

3. Plaintiffs Akron Center for Reproductive Health, Inc., Akron Women's Clinic, Inc., and WomenCare, Inc. ("plaintiff clinics") are Ohio corporations which provide family planning services in the City of Akron, including the provision of out-patient facilities for the termination of pregnancies through abortions. On or after May 1, 1978, plaintiffs face a loss of income and a deprivation of their constitutional rights should they comply with Chapter 1870, and a threat of criminal prosecution if they do not. Plaintiffs assert not only their own rights, but those of their patients as well.

4. Dr. Robert Bliss is a physician licensed to practice medicine in the State of Ohio who has performed, and

will perform, abortion procedures within the City of Akron. Dr. Bliss faces a loss of income and deprivation of constitutional rights if he complies with Chapter 1870, and a threat of criminal prosecution if he does not. Dr. Bliss asserts his own rights and those of his patients as well.

5. Defendant City of Akron is the Ohio municipality whose agents and officers enacted and will enforce, on its behalf, Chapter 1870.

6. Defendant John S. Ballard is the Mayor of the City of Akron and as its chief executive officer has primary responsibility for the execution of its laws, including Chapter 1870. He is named herein in his individual and official capacities.

7. Defendant Peter Oldham is the Police Prosecutor of the City of Akron and as such is responsible for prosecuting, on behalf of the City, violations of its laws, including Chapter 1870. He is named herein in his individual and official capacities.

8. Defendant Dr. C. William Keck is the Director of Public Health of the City of Akron and as such is charged with the duty to administer certain provisions of Chapter 1870, including those involving inspections and reporting. He is named herein in his individual and official capacities.

9. At all times relevant herein defendants have acted, and will act, under color of state law.

IV. Factual Allegations

10. Chapter 1870 was passed by a seven to six vote of the Akron City Council on February 28, 1978, and became law ten days thereafter. Section 3 thereof provides that it shall take effect and be in force as of May 1, 1978.

11. Chapter 1870 is the only legislation of the City of Akron which regulates a surgical procedure.

12. Upon information and belief defendants will seek plaintiffs' compliance with the provisions of Chapter 1870 and will cause criminal prosecutions to be instituted against plaintiffs for failure to comply. On April 4, 1978, counsel for plaintiffs requested assurance from defendant Ballard that the enforcement of sections of Chapter 1870 would be stayed pending an adjudication of their constitutionality (a copy of the correspondence transmitting that request is attached as Exhibit B to the original complaint herein). Defendants have provided no such assurance.

13. Compliance with Chapter 1870 will cause irreparable injury, for which no adequate remedy at law exists, to plaintiffs and to their patients, by depriving them of rights guaranteed under the Constitution and by increasing the physical and emotional risk attendant to the making and effectuation of the choice whether to carry a pregnancy to term or to end it by abortion. Furthermore, failure to comply with Chapter 1870 will cause plaintiffs to face criminal prosecution.

14. Plaintiffs also face significant economic harm should Chapter 1870 becomes effective, because it will discourage a large number of women from choosing to terminate their pregnancies in the City of Akron.

V. First Cause of Action (Substantive Due Process)

15. Plaintiffs incorporate herein by reference as though set forth in full the allegations of paragraphs 1 through 14.

16. Chapter 1870 deprives plaintiffs and their patients of the following liberties without due process of law,

in violation of the Fourteenth Amendment to the United States Constitution:

a. The right of their patients to make and effectuate the decision to terminate their pregnancy, a fundamental right of privacy guaranteed by the First, Fourth, Fifth and Ninth Amendments to the United States Constitution; see *Roe v. Wade*, 410 U.S. 133, 152-153 (1973).

b. The right of a physician to practice medicine in accordance with his or her best medical judgment, a right guaranteed by the First, Fourth, Fifth and Ninth Amendments to the United States Constitution.

c. The right of a physician to give, and of patients to receive, medical treatment and advice, in accordance with accepted medical standards, pertaining to the decision whether to terminate a pregnancy, rights guaranteed by the First, Fourth, Fifth and Ninth Amendments to the United States Constitution.

d. The rights of the plaintiff clinics to provide and their patients to receive counselling, education and other services relevant to the making and effectuation of the abortion decision, rights guaranteed by the First, Fourth, Fifth and Ninth Amendments to the United States Constitution.

VI. Second Cause of Action (Equal Protection)

17. Plaintiffs incorporate herein by reference as though set forth in full the allegations of paragraphs 1 through 16.

18. Chapter 1870 deprives plaintiffs and their patients of equal protection of the laws, in violation of the

Fourteenth Amendment to the United States Constitution, because it unreasonably singles out for regulation the abortion procedure, while all other comparable medical procedures are left unregulated.

VII. Third Cause of Action (Free Exercise and Establishment

19. Plaintiffs incorporate herein by reference as though set forth in full the allegations of paragraphs 1 through 18.

20. Chapter 1870 violates the prohibitions of the First Amendment against laws respecting the establishment of religion and interfering with the free exercise thereof, for the following reasons:

a. The purpose and effect of Chapter 1870 is to impede and/or prevent pregnant women from obtaining abortions.

b. Chapter 1870 constitutes enactment into law of one religious belief concerning abortions and the nature of the fetus, and constitutes the imposition of that religious view on women who would otherwise choose abortion in accordance with their religious or non-religious beliefs.

c. Chapter 1870 has no secular justification.

d. The enactment of this religious view into law has created and threatened further entanglement of Church and State and fosters political divisions along religious lines.

e. Chapter 1870 discourages, impedes, and/or prevents women from obtaining safe, legal abortions in accordance with the different teachings of the religions to which they adhere and/or with the dictates of their conscience.

f. Chapter 1870 forces physicians, under the threat of criminal penalties, to endorse and communicate to their patients one religious view regarding human life.

VIII. Reservation of Rights

20. Plaintiffs are asking leave of this Court to file this Fourth Amended Complaint. Previous amended complaints were filed pursuant to the Orders of this Court entered on April 27, 1978, May 3, 1978, and May 5, 1978. (All of which orders are hereby incorporated herein by reference). Said orders forbade certain persons, more fully described in the Orders, from proceeding in this action by fictitious name. Pursuant to this Court's Orders these persons have been stricken from this complaint. However, any and all rights to appeal the above enumerated Orders are hereby reserved.

IX. Prayer

WHEREFORE plaintiffs pray that this Court:

1) assume jurisdiction of this action;

2) issue a temporary restraining order, a preliminary injunction, and a permanent injunction restraining defendants and their employees, agents, and servants from enforcing Chapter 1870;

3) declare that Chapter 1870 violates the Constitution of the United States, as more fully set forth in plaintiffs' three Causes of Action;

4) award plaintiffs their costs and attorneys' fees, pursuant to 42 U.S.C. Section 1988; and

5) enter such other and further relief as the Court deems just and proper.

(By) /s/ Wayne G. Hawley

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Attorneys for Plaintiffs
on behalf of the American
Civil Liberties Union of Ohio
Foundation, Inc.

CERTIFICATION

A copy of the foregoing Plaintiffs' Motion to File a Fourth Amended Complaint and of the supporting Memorandum and proposed Fourth Amended Complaint attached thereto was mailed on the 17th day of July, 1978, to James L. Bickett, Assistant Law Director, 304 Municipal Building, Akron, Ohio 44308, and to David G. Umbaugh, 40 East Mill Street (at Main), Akron, Ohio 44308.

/s/ Wayne G. Hawley

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF OHIO
Eastern Division

Case No. C78-155A

[Filed: July 17, 1978]

AKRON CENTER FOR REPRODUCTIVE HEALTH, INC., *ET AL.*,
Plaintiffs

v.

CITY OF AKRON, *ET AL.*,
Defendants

Before Judge Contie

PLAINTIFFS' MOTION FOR THE SETTING OF A DATE CERTAIN

Plaintiffs respectfully move this Court to set a date certain for the hearing to be held in the above-captioned matter. Because of the large number of expert witnesses involved in this action, significant advance notice of the precise date of hearing is essential and will serve the interests of justice.

/s/ Stephan A. Landsman
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(216) 687-2529

Attorney for Plaintiffs
on behalf of the American Civil
Liberties Union of Ohio
Foundation, Inc.

PROOF OF SERVICE

A copy of the foregoing Plaintiffs' Motion for the Setting of A Date Certain was sent to James L. Bickett, 304 Municipal Builing, Akron, Ohio, 44308, and to David G. Umbaugh, 40 East Mill Street (at Main), Akron, Ohio, 44308, by ordinary U.S. mail this 17th day of July, 1978.

/s/ Stephan A. Landsman
Cleveland-Marshall College of Law
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Attorney for Plaintiffs
on behalf of the American Civil
Liberties Union of Ohio
Foundation, Inc.

DEFENDANTS' ANSWER TO FOURTH AMENDED COMPLAINT

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF OHIO
Eastern Division

Case No. C78-155A

[Filed: August 7, 1978]

AKRON CENTER FOR REPRODUCTIVE HEALTH, INC., *ET AL.*,
Plaintiffs

v.

CITY OF AKRON, *ET AL.*,
Defendants

Before Judge Contie

ANSWER OF DEFENDANTS, CITY OF AKRON, JOHN S. BALLARD, DR. C. WILLIAM KECK, AND PETER OLDHAM

Now come Defendants, City of Akron, John S. Ballard, Dr. C. William Keck, and Peter Oldham, and for their answer to Plaintiff's Fourth Amended Complaint state as follows:

First Defense

1. Plaintiffs fail to state a claim upon which relief can be granted.

Second Defense

2. Plaintiffs Akron Center for Reproductive Health, Inc., Akron Women's Clinic, Inc., and Womencare, Inc., lack standing to assert the rights of their patients and physicians against The City of Akron and certain officials responsible for the enforcement and administration of Ordinance No. 160-1978 as alleged in Paragraphs 1 and 3 of the Fourth Amended Complaint. Plaintiff, Dr. Robert Bliss, lacks standing to bring this action against The City of Akron and certain officials responsible for the enforcement and administration of Ordinance No. 160-1978, as alleged in Paragraphs 1 and 4 of the Fourth Amended Complaint.

Third Defense

3. Defendants admit that the statutes set forth in Paragraph 2 of the Plaintiffs' Complaint confer jurisdiction on this Court, but deny that the statements and allegations as set forth in said Complaint state claims within the statutory jurisdiction of the Court.

Fourth Defense

4. Defendants are without knowledge or information sufficiant to form a belief as to the truth of Paragraphs 3 and 4 of the Fourth Amended Complaint, but deny that Plaintiffs face a deprivation of constitutional rights should they comply with Chapter 1870.

5. Defendants admit Paragraphs 5, 6, 7, 8 and 9 of the Fourth Amended Complaint, but deny that the individual Defendants were properly named in their individual capacities.

6. Defendants admit Paragraph 10 of the Fourth Amended Complaint.

7. Defendants deny Paragraph 11 of the Fourth Amended Complaint.

8. Defendants admit that Plaintiffs will face prosecution for failure to comply with the provisions of Chapter 1870 as alleged in Paragraphs 12 and 13, but deny each and every other allegation contained in Paragraph 13 of the Fourth Amended Complaint.

9. Defendants deny that Plaintiffs face significant economic harm should Chapter 1870 become effective as set out in Paragraph 14 of the Fourth Amended Complaint. Defendants are without knowledge or information sufficient to form a belief as to whether Chapter 1870 will discourage a large number of women from choosing to terminate their pregnancies in the City of Akron.

10. Defendants deny Paragraph 15 of the Fourth Amended Complaint not specifically admitted herein.

11. Defendants deny Paragraph 16 of the Fourth Amended Complaint.

12. Defendants deny Paragraph 17 of the Fourth Amended Complaint not specifically admitted herein.

13. Defendants deny Paragraph 18 of the Fourth Amended Complaint.

14. Defendants deny Paragraph 19 of the Fourth Amended Complaint not specifically admitted herein.

15. Defendants deny both paragraphs numbered 20 of the Fourth Amended Complaint.

WHEREFORE, Defendants pray that the Court:

(a) Dismiss Plaintiffs' Fourth Amended Complaint;

(b) Dissolve the temporary restraining order previously issued by the Court in this action on April 27, 1978;

(c) Declare that Chapter 1870 does not violate the Constitution of the United States;

(d) Should the Court find that some sections of Chapter 1870 violate the Constitution of the United States, that the Court sever the unconstitutional sections from the constitutional sections and uphold Defendants' rights to enforce the constitutional sections of Chapter 1870;

(e) Deny Plaintiffs' request for costs and attorneys' fees; and

(f) Award Defendants their costs and attorneys' fees.

Respectfully submitted,

John E. Holcomb
Director of Law
The City of Akron

/s/ James L. Bickett
Assistant Director of Law
304 Municipal Builing
Akron, Ohio 44308
(216) 375-2034

/s/ Victor A. Dandrea
Assistant Director of Law

CERTIFICATION

A copy of the foregoing Answers was sent this 7th day of August, 1978, by regular mail, to Wayne G. Hawley, Attorney for Plaintiff, American Civil Liberties Union of Cleveland, Inc., 1223 West Sixth Street, Second Floor, Cleveland, Ohio 44113; to Stephan A. Landsman,

Attorney for Plaintiff, Cleveland Marshall College of Law, Cleveland State University, Cleveland, Ohio 44115; and to David G. Umbaugh, Attorney for Intervenors, 40 East Mill Street, Akron, Ohio 44308.

/s/ James L. Bickett
Assistant Director of Law
Attorney for Defendants

TRANSCRIPT EXCERPTS OF DR. ROBERT DALE CRIST

VOLUME I

[*Direct Examination by Mr. Landsman:*]

[24] Q. Are you currently licensed in any states, Doctor?

A. I am licensed in Kansas and Missouri.

Q. Are you Board certified in any specialty, Doctor?

A. I am Board certified in obstetrics and gynecology.

Q. Do you hold any degrees besides the M.D. degree?

A. Yes. I completed a Ph.D. in biochemistry.

Q. What was your military service in the medical context?

A. I spent approximately three years serving as Assistant Chief of Obstetrics and Gynecology and Research Coordinator at Walter Reed Army Medical Center in Washington, D.C.

Q. At that time, did you have any experience with the abortion issue?

A. Yes, it was approximately January of 1969 that a final directive came from the Department of Defense requesting that military regulations governing abortion and sterilization be updated to meet civilian standards.

As Assistant Chief, I was assigned the duty of working on that regulation.

Q. Doctor, do you have any publications?

A. In excess of 20 in the basic science and clinical area of obstetrics and gynecology.

Q. Have you done any consulting work, Doctor?

A. Yes, within the relevant field I have been a [25] consultant for the Upjohn Company in development of

prostaglandins in both induction of a term labor and abortion.

I have been a consultant to several other drug firms on Level 3 trials or Phase 3 trials of drugs, as well as a consultant to the March of Dimes.

Q. Doctor, have you ever consulted on teenage sexuality questions?

A. Yes. I am currently a member of a five-membered committee, appointed from the American College of Obstetrics and Gynecologists as a task force on adolescent pregnancy.

Q. What is your present position, Doctor; what is your employment?

A. I am a full-time member of the faculty at the University of Kansas, School of Medicine, where I carry a rank of Associate Professor in Obstetrics and Gynecology, and Assistant Professor of Biochemistry.

* * *

[28] Q. What are the relevant medical procedures for inducing abortion, Doctor?

A. Well, the relevant procedures really depend to some extent upon the stage of gestation.

For example, in a very early pregnancy, a procedure called menstrual regulation or menstrual extraction has been commonly employed.

This amounts to using a small, flexible tube and applying suction supplied either with a mechanical aspirator, a syringe or other suction device, and removing the products of the pregnancy.

[29] This applies up to about four weeks from the point of conception.

* * *

Classically, from about the 14th week until the 17th or 18th week has been described a gray zone. This is a zone in which technically performance of abortion was found difficult, and in the very early days was found to carry increased risk.

Following the gray zone, the classic approaches were [30] amniocentesis or placing a needle through the abdominal wall and into the fluid sack surrounding the pregnancy, removing part of that fluid and injecting either irritating dyes—the principal one called Rivinol—or Picric acid derivative imported from Japan, or hypertonic solutions, including hypertonic saline, urea and dextrose, and natural occurring products called prostaglandins.

All of these accomplished abortion by inducing labor.

More recent technical additions have gotten rid of the gray zone. These have been characterized as dilatation and evacuation or D and E, as it is commonly referred to.

* * *

[33] Q. In your practice, Doctor, do you use those procedures that you have described in the weeks you described them?

A. No, not totally. I carry the D and E procedure to approximately 21 weeks after the last menstrual period.

Rather than using a labor-inducing dose of urea after the 21st week, I use a combination of laminaria to dilate the mouth of the womb of the cervix, injection of urea overnight to soften the tissues and use a D and E procedure the following morning.

These I carry fairly routinely to 24 weeks, and in extreme medical conditions well past that point.

* * *

[35] Q. As a summary in terms of mortality, which is safer in terms of maternal health, pregnancy or abortion, by [36] comparatives?

A. Using first trimester legal abortion statistics, it is from eight to 35 times safer than is pregnancy to term and childbirth.

Q. Could you compare for us, Doctor, mortality experienced in the abortion context with mortality experienced in other medical or surgical procedures?

A. Yes. I think that is an interesting comparison.

For instance, in public health hospitals in the United States in 1969, this was 1281 hospitals involving over four million surgical procedures in ranging the number of procedures done; Procedure No. 21 was surgical removal of a tooth, where the incidence of death was 5.4 per 10,000 or 54 per 100,000.

Simple extraction of a tooth, because of decreased precautions and medical safety standards, carried an incidence of death of 174 per 100,000 procedures.

Let's take a very common situation, a penicillin shot given in a physician's office. This carries roughly the same mortality risk as a first trimester legal abortion, roughly 1.4 to two per 100,000 patients receiving penicillin injections.

* * *

[37] Q. Now, returning to that question, though, of the applications here in Akron.

A. There is no reason to believe that the medical community in Akron is any less skilled in providing medical services than the rest of the country.

In fact, I spent a good part of yesterday afternoon reviewing the records and going through a clinic providing first trimester abortion services in Akron.

In reviewing their records, it appears that their safety is even better than the 1.2 per 100,000.

Q. Thank you, Doctor. If you would reiterate, Doctor, [38] turning to second trimester abortions, which techniques are available for their effectuation? This is after the end of the first trimester pregnancy.

A. Still the most common technique used for second trimester is the injection, intra-amniotically of a hypertonic saline.

This is done roughly between the 18th and 24th week after the last menstrual period.

Of growing emphasis and obvious safety is the use of dilatation and evacuation, certainly through the 17th or 18th week after the last menstrual period.

This safety has been very nicely documented in publications from the physician group at the Communicable Disease Center, derived from their abortion surveillance statistics, comparing dilatation and evacuation with hypertonic saline and with the use of intra-amniotic prostaglandins.

Roughly from the end of the first trimester through the 20th week, the relative risk factors comparing dilatation and evacuation with, for instance, hypertonic saline, the risk factor is over two.

Comparing with prostaglandin intra-amniotically, that risk factor is 2.65.

* * *

[39] Q. Which do you rely on now?

A. I use the D and E procedures exclusively at this time, either with urea above 21 weeks or without urea prior to that.

Q. Was any distinction made between first and second trimester performance?

A. Yes. This distinction was made following publications by Dr. Tietze, based on statistics from surveys and statistics from studies in 1972 where he found the incidence of complications rising after the first trimester.

For this reason, with the importance of his position and the statistics he presented, there was a reluctance of a physician to try a procedure past the end of the first trimester, other than to delay and do an injection type labor induction termination.

[40] Q. What were the consequences of this distinction on the delivery of medical care?

A. The consequences were the creation of a gray zone where women seeking abortion services were delayed from 14 weeks until they reached 16 or 17 weeks.

Q. Where would those procedures be performed?

A. The injection procedures were done by and large in hospitals, based again upon Dr. Tietze's recommendation in his publication.

Q. Does this distinction remain valid between the first and second trimester, Doctor?

A. No, I think that distinction should be carried, rather than at the end of the first trimester, up to about 17 weeks.

Q. Why do you say that, Doctor?

A. Both from my own personal experience in performing roughly 12 to 15 hundred second trimester procedures per year, based upon statistics from the Communicable Disease Center, upon visiting at least five other clinics doing D and E procedures, and finally I think my view is supported by a recent decision of a New Jersey Medical Board to extend the right of outpatient clinics to do procedures to 17 weeks.

Q. Need early second trimester procedures, the ones you described, need they be performed in a hospital?

[41] A. No. In fact, my experience—and again supported by CDC statistics—the risks to the patient are less if the procedure is done in a free-standing clinic rather than in a hospital.

Q. Why is that, Doctor?

A. For one thing, most of the physicians working in free-standing clinics have extensive experience in performing vaginal abortion procedures.

While the less experienced physician will often use the hospital setting and general anesthesia to perform a second trimester procedure.

Secondly, physicians in training, residents, if you will, have their practices generally confined to the hospital setting and they are less experienced operators.

Many statistics will point out that they have an increased incidence of complications.

Q. Are early second trimester procedures being performed in clinical settings around the United States now?

A. Yes, they are. I know of several friends and associates who are doing them in New Mexico, in Texas, in Colorado, in California, in New Jersey, in Florida.

Q. Are they achieving the level of success that you have described previously?

A. Most of these statistics that the CDC has presented have been from five high-volume clinics doing second [42] trimester abortions.

One of those was the Hodari group in Detroit. Another is in Milwaukee; a third operates in Santa Fe and Dallas.

Q. In light of all these changes, at what date in gestation should pregnancy be required to be terminated in a hospital for medical reasons?

A. Well, in my estimation, I would place the requirement no earlier than the 17th or 18th week, and in the hands of very skilled operators who are in close proximity to a full-service hospital, I think that limit can be extended to perhaps as far as 20 weeks from the last menstrual period.

* * *

[43] Q. Doctor, is the Plaintiff, Akron Women's Clinic, adequately prepared to perform early second trimester abortions in a manner that will not increase risks to maternal health over equivalent risks in a hospital?

* * *

[44] ***The Witness:*** Yes. I visited the Akron Women's Clinic for three to three and a half hours yesterday and reviewed their records, their facilities, their equipment and found them fully adequate to perform second trimester abortions, in keeping with the standards prescribed by the American College of OB-GYN, and also those that we use within our own setting at the University of Kansas.

By Mr. Landsman:

Q. In your professional capacity, have you ever had occasion to review the quality of service delivered by any other abortion facility by examining it and going through it?

A. Yes. In 1972 the Kansas State Health Department was concerned after reports of unsafe conditions in a free-standing clinic in Kansas City, Kansas.

I was one of three physicians to examine that facility and make recommendations on its safety.

Q. Were your evaluations and recommendations accepted, Doctor?

A. Yes, they were, and the clinic instituted all of the recommendations that we offered.

The Court: The prior answer that you gave was that in many instances [45] a second trimester abortion can be performed more efficiently in a free-standing clinic than a hospital because the doctors are more skilled in many instances. They are doing a lot of this work; is that correct?

The Witness: That is correct.

The Court: How could you examine a clinic without checking the skill of the doctor and determine whether or not the clinic is qualified to perform second trimester abortions?

The Witness: I found that the facilities and equipment, resuscitative equipment, et cetera, necessary was present in the clinic.

I reviewed the records of the physicians and found that—

The Court: Assuming the skill.

The Witness: —that three of them had done extensive numbers of procedures and their operative morbidity and mortality was below that of published national standards.

I assume from that that they are skilled [46] operators.

The Court: Okay. Fine.

By Mr. Landsman:

Q. Doctor, what are the consequences to a woman if a second trimester procedure is not available in her community; health consequences?

A. This is a very common—has been a very common situation in the past, particularly in small rural areas.

The options open to the woman is to carry the pregnancy to term and deliver it, which increases her morbidity and mortality risk; to travel out of state where second trimester abortions can be performed, or to another neighboring community within the same state.

In those without money and unable to travel or secure second trimester abortions, they do resort to drastic means, such as self-abortion or criminal abortion.

Q. What are the health consequences of travel, if you travel outside your community to obtain a second trimester procedure?

A. There are several. There is a delay in obtaining those services. Usually there is a considerable period of time spent in searching, by telephone, by word of mouth, et cetera, as to where the procedure is available.

Secondly, one of the important parts of providing any surgical or medical service is follow-up of a patient.

[47] When she travels some distance, which may be as much as—I, for instance, receive patients from as far as 700 miles from Kansas City, and it is impossible for those patients to return to me for follow-up care.

In the rare instances of complications, physicians who are not experienced in following abortion patients and their difficulties afterwards often overreact and really overtreat the situation, and we see women who end up with hysterectomies, where simple administration of a medication to cause uterine contraction and antibiotics would have been fully adequate to treat her.

Q. What are the health consequences if she chooses that path which you described as most dangerous, illegal abortions or those that are self-induced?

A. Let's look, for instance, again at a few statistics.

If we compare survey statistics from 1969 and '70, there was a death rate from abortion of roughly 79 per 100,000 abortions performed.

Admittedly, those are survey estimates, compared with estimates today from 1.2 to 2.3 if we include the full range of first and second trimester terminations.

* * *

[59] Q. What is your general attitude toward parental notification and/or the involvement of parents in this question of teenage pregnancy?

A. I certainly feel that parental involvement is very, very important.

Number one, after an emotionally traumatic decision such as seeking an abortion and undergoing an abortion [60] procedure, most women, adolescents particularly, need a lot of core support. They need their family rallied behind them to say, "No, you did not do a bad thing. No, we love you. We support you. We are going to help you grow and mature through this experience."

For that reason, I think it is very important that the adolescent's parents be involved in her decision-making and be involved in the decision to have an abortion and the aftermath of it.

Q. Do you ever have adolescents who do not want to have their parents involved in this decision?

A. That is a very common situation for adolescents.

We have sort of a general observation that the younger the adolescent, the more advanced her pregnancy will be at the time she seeks abortion or prenatal services.

It is difficult for the adolescent to admit that she is a sexual being and that she might be pregnant.

It is only after a lengthy period of time that she will seek some outside help.

The last group that she wants to know about her sexuality are her parents, who have told her that this is not a thing that nice young girls do.

Now, there are other extremes where I feel that informing the adolescent's parents should not be done.

[61] Q. Well, before we get there, Doctor, what do you do with that young woman who comes in and says, "I don't want my parents to be notified"?

A. Well, first of all, the counselor, who is extensively experienced in dealing with these young women spends time exploring why she does not want her parents informed, why she does not want them involved.

Generally, her counseling session with them is able to convince them that it would be for their betterment, both today and in the future, to involve the parents in the decision.

If she is unsuccessful at that, then I spend time and we really try to convince the girl.

If there is still ambivalence on the situation, I have even suggested that we delay the procedure for one day and we go find the parents and bring them in and discuss it with them as a group.

Q. Now, the other side of the coin, Doctor, are there ever occasions where the young woman finally refuses to have her parents informed?

A. Yes, there are numerous instances of that.

Q. What do you do when that has taken place?

A. I generally perform the abortion.

Q. With or without notification?

A. Without notification or consent of the parents.

[62] A. Why, Doctor?

A. I feel that in my judgment as a physician, the welfare of that patient is my number one concern, and her welfare may be jeopardized, or in some instances would be jeopardized, in my estimation, by involvement of the parents in the abortion.

Q. In your professional opinion and in your experience, would it ever pose a physical threat to the pregnant teen to notify her parents of her inquiry about an abortion?

A. Yes. For instance, if the young woman who comes to me and explains her fear of parental notification is because her father or her mother or both of them are physically violent toward her, they have beaten her on many occasions in the past, the risk of physical harm to her is real and significant in those instances.

Q. Do those occasions occur, Doctor?

A. They certainly do.

Q. On a regular basis?

A. On a regular basis.

The other problem is the situation where a pregnancy has been conceived by incest. This involves very often a stepfather, in some instances an older brother or in a few instances a true father.

In those, notification of the parents is going to cause a major conflict within that family unit and often [63] physical harm to the young woman.

Q. Do you see those cases frequently, Doctor, or infrequently?

A. I was very surprised about three years ago, I prepared a series of abortion procedures by four different

techniques, a hundred patients in each series, a total of 400 for presentation in a district meeting of the American College of Obstetricians and Gynecologists. That was 400 consecutive procedures.

In that 400 I had 17 girls age 12 and under, and of the 17, 11 of them were pregnant by incest.

So, I would say, in my experience, it is a very common situation.

Q. Doctor, turning now from physical well-being to emotional well-being, would it ever pose a threat to an adolescent's emotional well-being to notify her parents?

A. Well, certainly in addition to physical trauma, in my estimation a form of child abuse is emotional abuse where the girl is berated, degraded by her parents following discovery that she is pregnant.

That poses a very significant emotional hazard to a young woman.

Q. Is that a frequent or infrequent occurrence, Doctor?

A. I find it to be a fairly frequent occurrence.

Q. Drawing on your experience and professional opinion, [64] is there ever a threat posed by parental notification to family stability?

A. Well, certainly in the case of incest the family is torn apart by discovery that a stepfather has been involved in an incestuous relationship with his stepdaughter.

In other situations, the usual reaction that we see of the father is to blame the mother, "You did not rear our daughter correctly; it is your fault that she is pregnant."

In many instances, probably counted in the hundreds in follow-up of the young women and of the situation

at home, I find that the involvement of the family has caused a disruption and a splitting of the marital pair.

* * *

[65] Q. Turning for a second to the other side of the coin, would it ever cause the parents of an adolescent who is pregnant any health-related problem if you notified them?

A. We certainly hear this request often, "My father is in the hospital with serious heart disease; my mother had a mastectomy last week and they found she was inoperable and she is very, very sick. I am afraid if she knows it, it may kill her."

I don't know how often this might happen, but certainly I realize that it poses a significant threat in those few instances to the physical well-being of one or [66] both of the parents.

Q. Why not just notify the well parent as opposed to the ill one in those cases?

A. That is hard to do, because in instances of serious health problems, there is usually a very close communication between marital partners, and it is difficult for one to hide information from the other.

So, informing one would be, in essence, informing the other in those instances.

Q. What effect, if any, would require a notification in all cases in which an adolescent seeks an abortion have on the likelihood of the performance of the abortion?

A. Well, it would certainly make a number of abortions impossible to perform.

Q. Why is that, Doctor?

A. There are instances where you actually cannot find the parents to notify them and get parental consent.

There are instances I have outlined where, in my professional judgment, it is advisable not to notify the parents, because of sequelae to their notification.

Q. Now, would a requirement of parental notification cause any problem to the physician in his practice as opposed to the adolescent in her life?

A. We in the medical profession really find acting as a policeman is a very foreign and distasteful thing and a [67] time-consuming thing.

I would say, as a general reaction of the physicians, when imposed upon them as a policeman, they simply avoid providing that service.

What I am telling you is it would reduce the number of providers or perhaps get rid of them totally.

Q. Returning to the teen, what is she likely to do if she lives in a community in a context where parental notification is required?

A. Well, if she is adamant in her decision not to notify the parents, she would travel, if financially available, any place she can to receive the abortion where parental notification and involvement is not necessary.

This can involve traveling hundreds of miles, costs involving several days of travel and overnight lodging, as well as I outlined before, the added risk of no follow-up care by the physician providing services.

Q. Are there any other responses that the adolescent would have?

A. Well, the others are she will give up and go ahead and carry the pregnancy to term.

Again, if we want to talk strictly in health risk, that is a greater health risk to her.

Alternately, if she is unable to travel, financially unable to travel, she may resort to attempts at [68] self-abortion. She may seek some very low-cost criminal abortionist or illegal abortionists that still exist today.

Q. What is the likely impact of a notification requirement on the date at which a teen will enter the health care network?

A. Well, the teen, as I outlined, the teen usually delays seeking services because she is afraid to involve her parents. She is afraid to tell her parents.

They have, shall we say, taught her from early childhood on that nice young girls don't involve themselves in premarital sex, and to admit she is pregnant is obviously an admission that she has been sexually active.

If we have a mandatory involvement of the parents before she can even seek information or services, there is going to be a considerable delay.

With delay we increase risks both, you know, physically and mentally.

* * *

[70] Q. Now, turn your attention to the other part of that section of the statute.

If parental consent were required, in all cases, [71] say those in which a judicial proceeding were involved for an adolescent under the age of 15 seeking an abortion, what would be the response of the adolescent to that double tiered structure?

A. Well, again, let me answer by reiterating the younger the adolescent the longer she waits before she can involve her parents in knowing she is pregnant and even when she wishes, in a decision-making process.

If parental notification is mandatory or parental permission is mandatory in all instances, the reaction of the

adolescent is going to be to drive or travel to where she can get the abortion or at least information and entry into the service without mandatory involvement of her parents.

The other options are to say, "I am just going to carry the pregnancy to term," or delay until that is necessary because she is past the point of safe abortion.

The third is resort to her own drastic means, self-abortion, criminal abortionists.

Q. Are the medical risks you outlined for us before with these options applicable here?

A. I think they are even more pronounced in the young adolescent, since statistically her risk of a health and emotional hazard associated with an abortion are higher than those of the women in age 20 to 24, for instance.

[72] Q. Would the requirement of parental consent in every case, say when there were judicial consent, create any problems in the practice of medicine for the physician?

A. Again, I will restate that acting as a police—acting as an enforcer is very foreign to the entire medical profession.

We are a crisis-oriented group to provide service at a time that it is needed and necessary.

The reaction is going to be to simply avoid providing these services, rather than involve ourselves in that type of activity.

Q. You may have already answered this, Doctor, but what effect, if any, would the parental/court consent requirement have on the likelihood of the performance of abortions on young teens?

A. It would certainly diminish it or make it essentially unavailable, particularly since we are talking here of a single city and the girl can travel one and a half or two hours down the road and find the same service.

It is really not going to deny her an ultimate abortion procedure. It simply delays her receiving that and increases her risk.

Q. Now, if that young adolescent, instead of going elsewhere or following the other outlined choices, attempts to avail herself of the judicial procedings, what [73] is the likely effect on her?

A. Well, I really have no experience with judicial proceedings in the State of Ohio. I can only speak from Kansas and Missouri where, number one, the adolescent views anything involving the court or legal matters as an actual enemy and she is very reticent to approaching those services in any way.

Rather than that, she will carry the pregnancy or she will delay until it is far too late.

Secondly, in those two states that I have outlined, the approach through the judicial system seems to grind notoriously slowly, and again we are imposing a delay that I find is risky.

* * *

[78] Q. How would you characterize the nature of these materials?

A. I have called them inflammatory and terrifying. I really consider them to be aimed in that direction.

Q. Do the materials in this section, .06(B), confine [79] the physician in his practice of medicine?

A. Well, no place else that I know of in medicine has the law come along and prescribed exactly what we must

tell a patient prior to performing any kind of surgical procedure in medicine today.

Informed consent is a matter that medical professionals implemented in informed consent. It is very meticulous in informed consent because of the malpractice issue.

I certainly feel that in my own experience and in my own visitation of clinics and the type of material handed to patients and presented verbally, informed consent is very properly presented in most abortion facilities, including the mention that the abortion could lead to loss of uterus, could even lead to death.

Q. I think you may have gotten a little off the track.

A. Okay.

Q. If you were required as a physician to comply with the requirements set forth in subsection six of Chapter 1870, what impact would that have on your practice?

A. Well, it would certainly reduce my practice of abortion.

Q. Why, Doctor?

A. Voluntarily I would find it distasteful and difficult to present this, and I would feel it was a dishonest [80] presentation.

Secondly, I am not wise enough to really predict the stage of gestation. I can't tell the girl, describe anatomically what the fetus looks like when the best I can do is perhaps plus or minus three weeks.

The whole thing is very vague. It is presented, in my estimation, as information to discourage the woman from seeking abortion services.

* * *

[81] Q. Doctor, what effect, if any, does the delay have on the delivery of medical care in general?

A. Well, delay in providing abortion services increases risks because pregnancy advances while you are delaying.

The more advanced, the greater the physical health risks.

Q. Is there any difficulty for the physician in delaying procedures?

A. Well, certainly most of us operate on a very busy schedule, and if the mechanics of delaying are going to occupy some of that time, most of us are going to avoid the types of things that require that delay.

By that, I am saying most of us would remove ourselves from the performance of abortion.

Q. Which women would face the most significant health risk from delay?

[82] A. Well, the very young, because their entry into the health service system in seeking an abortion is later than older women.

The very poor and uneducated, because of their inability to articulate their needs and fight their way through the red tape of a system.

All of these are the ones that are going to be most hampered by any delay, mandatory delay procedure.

Q. What effect, if any, will delay have on the cost of performing abortions?

A. Well, if we implement a record keeping and paperwork system, then it requires more people. More man hours mean more wages and that cost is simply passed on to the consumer, namely the girl seeking an abortion. It will raise the cost.

Q. Could as short a time as 24 hours increase a health risk in the abortion context?

A. I referred to that before. I am not willing to say that 24 hours is going to be a very significant rise in health risks, in terms of physical health.

In terms of mental turmoil and torment the girl is going through, 24 hours may mean a great deal.

It may be a period of time that will tip her to doing drastic things, such as self-abortion or other such things, getting in her car and driving someplace else to [83] seek the abortion procedure.

* * *

[*Cross-Examination by Mr. Bickett:*]

[97] Q. Doctor, let me ask you this also: Dealing with individuals under the age of 15, after the abortion is performed, based on your training, the books you have read, the articles and your own experience, in your opinion, do these individuals go back to the family unit which they left after the abortion is performed?

A. The general rule is they return to the living unit they were in upon becoming pregnant, whether this is a family unit or not.

The young, pregnant adolescent often is not in a usual structured family environment.

So, no, I would not say that they return to the family unit. We are talking about 11, 12, 13, 14-year-olds who become pregnant.

These are generally girls, as I described, these are the prime ages for incest pregnancies. These are the prime ages in the very early teens for the young girl in flight leaving her home, living with a girlfriend, living on the street, living with an older male.

[98] Q. Doctor, so it is your testimony then, even in cases such as the case you have just mentioned of

incest, that if the individual 14 years of age or younger should become pregnant by incest, that after having the abortion, without anyone in the living unit knowing about it, they would be returning to that same living unit after the abortion procedure?

A. Generally in incenst cases, that is not correct.

As I testified earlier, incest cases are usually not brought by either of the parents of that home, but by an interested third party.

As I believe I testified earlier, it is this third party that we request inform authorities. These are the girls who are usually removed and placed in custody of a court as a result of the incest charge.

These are always investigated by the juvenile authorities.

So, no, those girls are not sent back to that same home environment.

Q. Does your clinic, in all cases of incest, instigate the investigation or inform the authorities?

A. Our clinic, as I testified earlier, does not in all instances, but we seek the assistance of the interested third party who usually accompanies these very young girls.

[99] This is often somebody from Social Service, incidentally, or from the school system.

* * *

[*Cross-Examination by Mr. Bopp:*]

[106] Q. * * * For minors, what are the normal reasons for obtaining an abortion?

A. The usual reasons for obtaining an abortion?

Q. Yes, sir.

A. What age group would you like me to run—would you like me to run by age groups?

Q. All less than 18 years of age.

A. Well, the usual is that it was an unplanned, unwanted, undesired and untimely pregnancy in the sense that it would constitute an interruption of her education, her social advancement and so forth.

[107] When we drop below the age of 15, however, we have very, very serious maternal health and fetal health problems that are considerations that many of us consider abortion highly recommended.

For instance, may I cite that a fetus or a child born to a woman under the age of 15 has an average IQ 15 points below the national average. Its birth weight is three quarters of a pound less than the national average.

* * *

[108] Q. So what we are usually involved with in an abortion to a minor is an abortion where it is to be performed for economic, social reasons, rather than medical reasons?

A. I would personally disagree with that statement.

As I outlined before, I feel that the medical reality of mortality risks to the under-15-year-old girl and the outcome pregnancy, outcome risks are true medical indications for abortion.

Q. Is it your opinion, therefore, that there is a medical indication for abortion for every pregnant girl under the age of 15?

A. It is my personal opinion; that is correct.

* * *

[115] Q. Don't you think parents are in the best position to provide you with additional information to determine what is in the best interest of the minor?

A. Absolutely. Parents are in a far better position. In every instance I can, I involve the parent.

* * *

TRANSCRIPT EXCERPTS OF KATHLEEN GOTSHALL

VOLUME I

[*Direct Examination by Ms. Roberts:*]

[127] * * *

Q. Ms. Gotshall, the services that Akrion Center provides, you mentioned pregnancy testing. What is the cost of that service?

A. It is a free service.

Q. The abortion procedures themselves, what is the cost of those procedures at Akron Center?

A. As of August 1st, it is $175 for local anesthetic procedure, $210 for a general anesthetic procedure.

There is a reduced rate for women who are on ADC, Aid for Dependent Children.

* * *

A. The various services that are provided, counseling, [128] the testing, pregnancy testing, abortion procedures that you mentioned; are those scheduled at different times?

A. The abortion procedures are scheduled for Wednesday and Saturday only.

* * *

[131] *The Court:* A lot of your patients come through newspaper advertising; is that correct?

The Witness: Some do. The majority of our patients come from social service referrals.

* * *

[140] Q. Would she be able to obtain—do you refer her to any place in Akron for a second trimester procedure?

A. Not any longer, no.

Q. Why is that?

A. Very simply, we do not know of any physicians who will provide second trimester abortions in a hospital any longer in Akron.

* * *

[153] Q. Now, have you had occasion to do any statistical survey of the complications, the complication rate among patients who have received abortions at Akron Center?

A. Yes.

Q. Referring you to Plaintiff's Exhibit 19, on page two of that exhibit, would you read what it says under No. 9, Mrs. Gotshall?

A. "Known complications: A total of nine patients had to have a repeat D and C. This is less than one percent. Specifically, .08 percent or eight tenths of one percent.

"We have had no major complications during the period indicated," which was May of '77 to December of '77.

Q. How many patients did that period include, Ms. Gotshall?

[154] A. 1,250 patients.

Q. Again, is that information correct, to the best of your knowledge?

A. To the best of my knowledge.

* * *

[160] Q. Ms. Gotshall, have you counseled young women of the age of 14 or 15 whose parents were unaware of their decision to seek an abortion?

A. Yes, I have.

Q. Did you inquire into the reason why they had not informed their parents?

A. Yes.

Q. Do you and do the other counselors at the Center encourage women under the age of 18 to inform their parents that they are seeking an abortion?

A. Yes.

Q. And of those that refuse to do this, do you still perform an abortion for them?

A. Yes.

Q. Have you had occasion to have young women of this age explain to you why they feel they cannot or do not want to inform their parents?

A. Yes.

Q. What kinds of explanations do you get?

A. The primary explanation would deal with—and the circumstances will vary, but in a fear of telling the parent that she is pregnant, and, therefore, admitting that she has been sexually active.

[161] Q. In terms of women under the age of 18, is there special counseling done or special attention given to young women in the counseling sessions with respect to determining their decision-making process about having an abortion?

A. The counselor would certainly be aware of the ages of her patients, and special attention, I would say, yes, would be given to the minor to not only determine whether or not she is firm in her decision, but whether or not she understands what is about to happen.

Q. Are there occasions when it is determined that she

either is not firm in that decision or she does not really understand?

A. Yes.

Q. After efforts to resolve those problems, is there still some difficulty with respect to that young woman's making the decision; has she ever been refused an abortion on that basis?

A. Yes.

Q. At your Center?

A. Yes.

Q. Specifically why?

A. If we do not feel that a woman has firmly made up her mind to abort, we will not do the procedure.

* * *

[162] Q. Directing your attention to Section 1870.07, the ordinance requires that 24 hours elapse from the time a woman seeking an abortion has signed the consent form that is required until the abortion can be performed.

What would be the impact of this required waiting period on, first of all, the patients at your Center?

A. If a woman is coming to the Center for an abortion procedure and is coming from out of town, it may very well involve an overnight stay in Akron, which could mean possibly two days, loss of work time for her, or she may incur other expenses, day care expenses, babysitting [163] expenses might be involved.

Also, if she is scheduled for a general anesthesia, someone does have to accompany her. So, those same expenses could be incurred by another party.

Q. Now, general anesthetics are given when, on what days of the week?

A. On Saturday only.

Q. So if a woman came to the Center, had her counseling, signed her informed consent form on a Friday afternoon, is it possible she might—and needed a general anesthetic, that is, a general anesthetic was indicated or she elected to have a general—is it possible she would have to wait another week for the abortion?

A. Yes, very definitely.

Q. And might that, if she were in the 12th week, then preclude her being able to obtain an abortion at the Center?

A. Yes.

Q. What problems would the waiting period of 24 hours provide for the Center in terms of additional staff or additioanl hours?

A. Well, additional staff would be required as well as the physician's time.

Therefore, a greater expense to the clinic, yes.

Q. Now, you mentioned the involvement of the additional [164] time for the physician.

Turning your attention to Section 1870.06, page four of the ordinance, .06 requires that the physician give certain information to the patient in order to inform her fully for her consent under the ordinance.

Now, would you please describe the additional physician time that would be involved with the requirement that the information for the informed consent must be provided for the physician, and that a 24-hour waiting period would be required for that consent.

A. As far as the amount of time that a physician may have to spend, 24 hours ahead of the abortion procedure?

I am sure that it could vary, depending upon the questions that a patient may have concerning the procedure.

I am sure that it could vary from a few minutes to conceivably hours.

Q. You mentiond that procedures are done on two days a week; is that correct?

A. Yes.

Q. And are the physicians that provide medical services at the Center typically at the Center other than those two days?

A. No.

* * *

[167] Q. Now, under the ordinance, if that information must be presented to the patient by the physician, you suggested [168] that it may involve an additional day of the physician's time; is that correct?

A. Correct.

Q. Can you give an estimate about how much more in additional time, an additional day of the physician's time is going to cost the Center?

A. Depending upon the length of time the physician spends at the Center—and I think Dr. Crist testified that a physician may be required to have his payment anywhere from maybe 25 to 50 to 85 dollars an hour, depending upon the length of time, two, three hours at the Center.

It could conceivably cost the Center $250 or more.

Q. On that basis, would the Center be required to increase the cost to the patient for the abortion procedure?

A. Yes.

* * *

[*Cross-Examination by Mr. Destro:*]

[213] Q. Do you consider parental consultation as a counselor, in your experience as a counselor, to be helpful to minors age 15 and under?

A. Sometimes.

Q. On what do you base your sometimes answer? When can it be and when would it not be helpful, in your judgment?

A. If that consultation will be supportive of the patient, then it will be helpful.

Q. When you say "supportive of the patient," does that mean supporting the patient's ultimate decision?

A. Yes.

Q. Then is it fair to say then that you would not consider counseling helpful which might disagree with the minor's decision?

A. Which might be very disruptive, yes, to the minor-parental relationship.

* * *

VOLUME II

[*Recross-Examination by Mr. Bickett:*]

[27] * * *

The Court: What was your field of major in college?

The Witness: Sociology and political science.

The Court: Have you had any medical training of any nature?

The Witness: No formal medical training, no.

[28] *The Court:* Any religious training, other than attending church or going to Sunday school or anything of that sort? Do you have any religious training?

The Witness: Religious training, no.

* * *

TRANSCRIPT EXCERPTS OF DR. CHARLES V. BOWEN

VOLUME II

[*Direct Examination by Mr. Hawley:*]

[30] * * *

A. My name is Charles V. Bowen, M.D.

Q. You are a licensed physician in Ohio?

A. I am.

Q. Do you practice here in Akron?

A. Yes, since 1949.

Q. What is your specialty, Dr. Bowen?

A. Obstetrics and gynecology.

Q. Are you a member of any professional medical societies in Summit County?

A. I am a member of the Summit County Medical Society, the Akron Obstetrical and Gynecological Society.

Q. Are you an officer in any of those societies?

A. I am Secretary of the Summit County Medical Society.

Q. Are you a committee member in any of those societies?

A. I am a committee member of the Maternal and Infant Health Committee.

[31] Q. Are you a past officer of that Maternal and Infant Health Committee?

A. Yes, I was Chairman for about 10 years.

Q. When did your term expire?

A. This year, when I became Secretary of Summit County Medical Society.

Q. Have you had occasion, Dr. Bowen, to inspect any of the abortion clinics here in Akron?

A. Yes, I have had an occasion to inspect all three of them.

Q. When did that occur, sir?

A. About January of this year we went through them twice, on two different occasions.

Q. When you say "we," who is that?

A. The Summit County Medical Society. We had an Audit and Review Committee for this occasion. It consisted of Dr. Keck from the Public Health Department, Dr. Ernest Estep, who at that time was Medical Director of Planned Parenthood, and myself who was representing the Summit County Medical Society and the Maternal and Infant Health Committee.

The Court: Do I understand, sir, you examined the facilities?

The Witness: Yes.

The Court: Is that correct? [32] Were you there during the course of the days that any of these clinics were performing abortions?

The Witness: I witnessed one in every one of them.

The Court: One in every one, you were there?

The Witness: Yes.

* * *

Q. Regarding Plaintiff's Exhibit 50, Dr. Bowen, who authored that document?

A. I beg your pardon?

Q. Who authored it, wrote it?

A. The Council of the Summit Medical Society agreed that several of us should testify at the City Council

meeting, and I was selected as one of those to [33] testify. I wrote this myself.

It was certainly preread by the President and the Executive Secretary of the Summit County Medical Society, but I personally wrote it.

* * *

Q. Does this Plaintiff's Exhibit 50 express the views of the Council or yourself or both?

A. I would say definitely both.

* * *

[34] Q. Regarding the sentence I just read, Dr. Bowen, is that in fact your opinion, that there is no medical need for an ordinance?

A. Yes, it is. I repeat, after we have had the opportunity to inspect all three clinics and they cooperated with us very well.

Q. Again, turning your attention to the statement near the bottom of the second page, the last full paragraph on the page concludes with the words, "Up to this point in time, the abortion clinics are doing an adequate job."

Do you stand by that statement, Dr. Bowen?

[35] A. I do.

Q. Again, on the second page of Plaintiff's Exhibit 50, the previous paragraph to the one I just read concludes with the sentence, "The SCMS was not asked for any professional advice by the proposers of this ordinance;" is that true, to the best of your knowledge?

A. It is definitely true to the best of my knowledge, yes.

* * *

[*Cross-Examination by Mr. Dandrea:*]

[43] Q. Can you state, if you remember, Doctor, how long you stayed at Women Care?

A. I would say at least an hour.

* * *

Q. And in the course of that time that you were at Women Care, did you witness any counseling being performed by the counselors with any prospective women to have abortions?

A. I did not hear what was being said, but I mean, as we went by, they said, "In this room there is a counselor talking to one of the patients."

* * *

[45] Q. After your visit to Women Care, Doctor, did you make any recommendations to the Director with respect to changes that should be undergone at that clinic?

A. Specific ones, you mean?

Q. Yes.

A. Yes, there were a couple in the way the physical layout of the room arrangement was. We felt that a few things could be changed, which they did, in an architectural way.

In the beginning we were a little concerned somewhat about their sterilizing technique, which was certainly corrected.

* * *

[46] Q. You mentioned, Doctor, you visited each of the other two clinics?

A. Yes.

Q. How much time did you spend at the Akron Center for Reproductive Health?

A. I would say about the same amount of time.

I mean, because after I made a tour of the place, we did, Dr. Estep and myself for sure, on that one, the first time around, I am talking about.

Then we sat down and talked to the supervisor, you know, the Director, and asked her certain things about fees and what they included, you know.

So, we spent, I would estimate, certainly 45 minutes to an hour there.

Q. Did you witness any counseling there, Doctor?

A. Only from the same standpoint, where I actually saw a patient in a room with a person talking.

I do not know who the counselor was or her credentials or anything else. I did witness two people in a room talking.

* * *

[47] Q. With respect to that doctor at Akron Center for [48] Reproductive Health, would it be fair to say, Dr. Bowen, that on that occasion that doctor had little or no conversation with that patient before performing the abortion?

A. Yes, I would say he was, you know, until she came in the room and was on the table, prepared, he spoke to her.

I mean, that is all I actually saw. I am assuming that they had a conversation somewhere before that, because they usually are certainly examined by someone before the abortion is performed to determine how far along they are and everything else.

I am certainly assuming that he saw her at some time before the abortion was actually performed.

* * *

[49] Q. With respect to all three clinics, do you have a recollection, Doctor, whether or not on the visits to each of those three clinics you saw a physician counseling a group of women or an individual woman outside the Operating Room or a place set aside for operating?

A. No, I did not see that in any of them.

* * *

[50] Q. Would it be fair to say, in other terms, then, Doctor, that you had some concern on the visit at least to one of these clinics that perhaps they were trying to do too many procedures on a given day?

A. I don't know whether I could say they were doing too many, but I thought the setup in the beginning, that they would have to prove to have enough—I mean, enough equipment and everything else to do the volume.

* * *

[51] Q. * * * Doctor, would you state, then, in your own terms, why you visited the clinic, either the first time or the second time?

A. Very definitely. Because the Summit County Medical Society, if there were going to be abortion clinics in Akron, the one and only thing that we were concerned about was that they were going to be well run medically, and that was the only thing that we really felt our duty was.

So, as long as all three clinics so far have allowed us to come in voluntarily to inspect them to our satisfaction, then we feel very comfortable with the whole situation and we see no reason to change that.

Q. Upon your visiting the clinic January, March of 1978, some of these clinics had been in operation for at least 14 months; isn't that so, Doctor?

[52] A. That is true, but by the time we got our mechanism—after all—we feel this is our responsibility, very definitely, but by the time we got the mechanisms together and decided who should do it and what representation we should have, well, it just took that long to do it.

Even now we have no decided exactly how often we think we should go back.

Since this ordinance has come up, why, we are not quite sure where we stand.

Should we continue to press and take it over ourselves or wait and see what somebody else is going to do?

But, we had several meetings on the way to handle this whole problem about the time that the ordinance was introduced, and it is certainly being followed through to some degree. But, as to how often we feel we should check these clinics now, why, it really has not been decided.

But, if we are left alone, I am sure we will.

Q. May I direct your attention, Dr. Bowen, to Exhibit 50 in front of you, page three, paragraph one, the last sentence:

"We did not realize that the ordinance would be amended as it was or we would have spoken out against it much sooner."

Would it be fair to say that the proposed ordinance [53] here and publicity surrounding it was what prompted your visit and your fellow colleagues to these clinics in January and March of '78?

A. No, I do not think that at all.

When the Supreme Court ruling first came down, we immediately, the same month, through our City Council or through our Medical Council, why, our own Maternal Infant Health Committee and the Public Health Committee drew up what we called some guidelines with the idea—at that time, there were no clinics open, but we drew up guidelines that hopefully that anyone who was going to open a clinic would be willing to follow.

Remember, we had no enforcement on these things. We can only ask for their cooperation.

The things that we were mostly concerned about then was the caliber of doctors who were doing the abortions or who would be doing them, and the facility where they would be done.

In the beginning we even hoped maybe one or two of the hospitals would be able to have a space, you know, for a clinic like this rather than having a separate entity like they are now.

But, of course, nothing ever came of that.

I am just saying, from the word go, we certainly got involved. Whether 14 months is a long time to make the [54] first inspection, well, maybe. I don't know.

But, once we did get into it, then we certainly, I think, followed through pretty well.

Q. May I ask, Doctor, what other clinics or type of clinics do you personally or do other representatives of the Summit County Medical Society visit?

A. No, because most of them, we assume were sort of under the jurisdiction of Dr. Keck, you know, and the Public Health.

We have an excellent—one of the best in the country—review systems for the homes for the—whatever you want to call them—the old people. All the nursing homes are inspected every month by doctors.

I certainly don't go over too often anymore, but in the beginning, when the Health Department set up their prenatal clinics, which I personally helped with, I used to go over and visit and just watch how things were done there. It was run mainly by the residents from the different hospitals.

* * *

[61] ***The Court:*** So, therefore, if a clinic did not have pre-examination by a physician of females prior to the time they are brought in the room for performing the abortion, then the statement that was made of the physicians, of the SCMS are only interested in making sure that all abortion clinics are well run from a medical viewpoint and up to this point in time the abortion clinics are doing an adequate job; then you assume from that [62] that pre-examinations were made prior to the time the abortion is being performed. Is that correct?

The Witness: Absolutely, to the best of my knowledge.

The Court: That would be essential?

The Witness: Sure, yes.

The Court: If they were not, those examinations were not being conducted by a physician, then—

The Witness: Then I would say they ought to be closed up.

* * *

[63] Q. One question, following up on that.

The pre-examination you are referring to is a pelvic examination by the physician; is that correct?

A. Yes.

* * *

Q. Does the pre-examination include counseling, Doctor?

A. It is my understanding, to my understanding, yes.

I mean, if I can believe them, what they tell me their procedure is, yes.

* * *

TRANSCRIPT EXCERPTS OF DR. FELIX P. HEALD

VOLUME II

[*Direct Examination by Mr. Landsman:*]

[67] Q. Are you a licensed physician, sir?

A. Yes, I am.

Q. Where are you licensed?

A. Pennsylvania, Massachusetts, District of Columbia and Maryland.

Q. Are you Board certified in any specialty, sir?

A. Yes, pediatrics.

Q. With any subspecialty of that?

A. Adolescent medicine.

Q. Do you have any articles in publication?

A. Yes.

Q. In what field?

A. Adolescent medicine.

Q. Are you a member of any learned societies, sir?

A. Yes, the Society of Pediatric Research, American Pediatric Society, American Academy of Pediatrics, Society of Adolescent Medicine.

Q. Do you have any honors, sir?

A. Yes.

Q. What are they, sir, if you can recall? Or are they simply in your vitae?

A. Pardon?

Q. Are they recorded in your vitae?

A. They are recorded.

Q. Do you do any consultations at this time, sir?

[68] A. Yes.

Q. Of what sort?

A. For the Federal Government, I serve on two consulting groups for two different parts of HEW.

Q. What are those consultations involved with?

A. Well, the one committee that I have been on is Maternal and Child Health Committee of HEW, which is research review on it.

Q. What is your present position?

A. I am Professor of Pediatrics at the University of Maryland, School of Medicine, and Director of the Division of Adolescent Medicine at the University Hospital.

* * *

[77] Q. When you say "particularly very young," what age do you mean, sir?

A. I am talking about the 15 and under.

As the whole issue of teenage pregnancy is clearly related to maturation and age, and since age is probably the best issue of maturation that we have, the younger the teenager the more adverse is the outcome of the pregnancy likely to be.

* * *

[78] Q. What is the length of gestation at the time of abortion for adolescents, when do they come in for the abortion?

A. Unfortunately, they tend to come in late, later than other women.

Q. Does the delay have any health-related consequences?

A. Yes, it does, clearly does.

The later they seek abortion or prenatal care, the more adverse it is.

Q. Why do adolescents seek abortion at a later time in their pregnancy generally, or seek care later in their pregnancy?

A. Well, there are multiple reasons.

In the first place, they are not as experienced in recognizing pregnancy. They tend to deny pregnancy if they suspect it, because it is such an unpleasant thought.

[79] They are fearful of the reaction of people around them, their peers, their parents. They are afraid to tell anyone.

They are afraid; they do not know the medical system. If they want to seek help alone, they are afraid of the medical system and do not know it well, so almost everything tends to delay and is against early entry into the system, which is in their favor.

Q. As a medical matter, what are the complications of this delay?

A. Well, again, the later one deals with the issue of pregnancy and deciding whether to carry to term or to seek an abortion, the more adverse is the outcome theoretically.

Q. Knowing these factors, what do physicians who deal in the area of adolescent medicine do in providing health care to adolescents?

A. Well, they try to create a system which removes as many impediments to medical care and the decision-making process that the teenager and their family, if they are involved, need to go through in coming, arriving at an appropriate decision.

* * *

[80] Q. Doctor, what is your general attitude about parental involvement in the provision of medical care, including abortion, to adolescents?

A. Our position is very clear. We encourage the teenager to seek parental involvement and encourage them to be involved in the decision making so they can support their daughter in whatever they decide to do.

Q. Have you ever encountered situations in which an adolescent refuses to have her parents involved in such a way?

A. Yes.

[81] Q. Has this occurred in the abortion context specifically?

A. Yes, it does occur with some frequency, particularly in the older teenager, the teenager who tends to be more independent and/or who has been in many ways abandoned by their parents, parent or parents. They will, you know, seek their own.

Q. What motivates this adolescent's resistance to parental involvement, if you know, sir?

A. Well, their reason that they give us is that, "My parents would be so angry they would kill me."

These are words that I have heard a number of times.

So, it is fear of parental disapproval and real anger and nonsupport.

They just do not want their parents to know, and they are adamant about it.

Q. Are these fears and perceptions realistic, sir?

A. Oh, I think so. I think we have had—clearly our experience has been that when youngsters have been fearful but have decided to involve their parents, that

their fears have been realistic, that they have had a hard time with their family.

* * *

[83] Q. Can an adolescent give her informed consent to abortion; is she capable of making that decision without parental input?

A. Yes, but I think it needs to be qualified.

I think it is age related.

12-year-olds, for example, I think it would not be appropriate.

There are some 14-year-old youngsters who are mature enough, who I would respect and feel that they understood the issues and could make the decision, but certainly 15, 16, 17-year-olds, by and large, the older they are the more capable they are of making an understandable and conceptual decision.

* * *

[86] A. * * * Generally, teenagers, if you treat them as adults, they tend to be intimidated easily. They are unsure of themselves, and they do not respond. They do not have the coping skills that adults have, and this is why, in part, there are teenage clinics.

Q. Are their responses different from those of adults in these exchanges between physician and patient?

A. Yes.

Q. In what ways?

A. They tend to be less responsive. They do not have the confidence to engage in the kind of conversation that an adult would with their physician.

Q. Why is that?

A. I think in part they are frightened. They do not have the experience.

Fear of the big medical system and health system is how they measure it.

* * *

[*Cross-Examination by Mr. Bickett:*]

[91] Q. At your clinic, approximately how long does each patient go through abortion counseling prior to the [92] procedure?

A. It varies. Some youngsters it can be done in an hour. Other youngsters, it will take multiple hours.

It depends on the nature of the issues involved, the age of the youngster.

Q. At some time prior to the procedure itself, is it part of your clinic's requirement that someone with medical training or background talk to the individual?

A. No. Medical training, I am not sure what you mean. You mean M.D., nursing?

Q. A degree in the medical field, nursing, M.D.

A. No. Well, the initial counseling is given either by a physician or one of our nurses. That just happens to be the way we are staffed.

Q. Do you think it advisable that they receive counseling from a nurse or a doctor, someone trained in the medical field?

A. I think at one point they should be, yes.

Q. Should this counseling by the physician or nuse take place well in advance of the procedure; should there be a time lapse between the counseling and the procedure itself?

A. Not particularly. Again, it is an individual matter.

Q. Should the counseling, as a typical matter, take [93] place in some place other than the procedure room?

A. I think the setting is irrelevant. I think the cast of people is highly relevant.

Q. Earlier you gave statistics on mortality rates, I believe, for childbirth.

Do you have a comparison between the mortality rate for adolescents for an abortion versus the mortality rate for adults in the abortion, when having an abortion? Is there a comparison there?

A. I would have to check and look.

Q. Well, could you?

A. Which I can.

Q. Do you know whether the mortality rate for minors is higher than that for adults?

A. In abortions?

Q. In abortions.

A. I am uncertain. I don't know.

Q. Do you know whether or not the morbidity rate is higher for minors in performing an abortion than it is for adults?

A. I am uncertain, but I could sure find out pretty fast.

* * *

[*Cross-Examination by Mr. Destro:*]

[100] Q. Are you aware or have you done any psychological studies on your minor patients with regard to any subsequent psychological complications they might have had?

A. I am aware of the literature.

Q. Do minors, in your experience, suffer psychological complications?

The literature suggests that those youngsters who are emotionally healthy prior to abortion remain so afterwards, and those who are emotionally disturbed before abortion are emotionally disturbed afterwards.

There are two different—there are differences following abortion in teenage behavior.

One is that they would not like to have an abortion again. Secondly, they are consistent contraceptive users.

* * *

[107] Q. Do you have any basis or any information relating to the type of guilt that minors feel, where it is derived from?

A. I am not sure what you mean by type.

Q. Would the guilt, for example, that you say that minors feel relate, for example, to parental attitudes that the minors might perceive their parents as having?

A. Well, it is a society guilt.

Generally, teenagers are not expected to be pregnant.

The guilt is less now than it used to be, but it is a pervasive society and has, in the past, been a pervasive society taboo.

That residue still is with us, and there is not a teenager that we see that is not upset and guilty about being pregnant.

I don't see any need to intensify that.

* * *

[109] Q. In your judgment, Doctor, is it advisable for a doctor to delegate the information gathering process from a minor to a surrogate, such as a counselor or a nurse?

A. Some counselors are much better counselors than physicians.

Q. In terms of gathering a medical history, for example, Doctor?

A. Some nonphysicians are much better than physicians in gathering information from teenagers.

* * *

[110] Q. In your judgment, Doctor, are adolescents aged 15 and under generally able to give you an adequate medical history of themselves?

A. Yes, they are pretty good.

* * *

TRANSCRIPT EXCERPTS OF NORMA GOLDBERGER

VOLUME II

[*Direct Examination by Ms. Roberts:*]

[123] * * *

Q. In what capacity are you employed?

A. I am the Clinic Coordinator.

Q. As Clinic Coordinator, would you describe your duties and responsibilities?

A. I hire and fire all employees, coordinate the time, the patient appointment times with physician availability times, pay invoices, order supplies.

I do some public relations.

Q. This would be general administration of the clinic?

A. That is correct.

Q. Ms. Goldberger, would you please describe your educational background?

A. I have a Bachelor's and Master's from the University of Toronto, medical sociology.

I have completed my Doctoral comprehensives at Boston College, all but dissertation.

In addition, I spent one year at Florence Heller School of Social Work, Brandeis University, and one year at the University of Michigan School of Medical Health Medical Care Organization.

Q. Where, prior to the opening of Akron Women's Clinic, where were you employed?

A. The professional jobs that I have had—I was a [124] college teacher at a junior college in Boston and then after that I was the coordinator of problem pregnancy counselor at a free clinic in Columbus, Ohio.

Then I was a counselor at an abortion clinic at Columbus, Ohio.

Then I was a director of an abortion clinic in Columbus, Ohio.

Q. That directorship at the clinic in Columbus was immediately prior to coming to Akron?

A. Coming to Akron, yes.

* * *

[127] Q. Now, does that mean that you do not provide second trimester abortion procedures at your clinic?

A. Yes.

Q. Is there a reason for that? Why don't you provide second trimester procedures?

A. We do not because the original Akron ordinance law that was passed a year ago said that we were only [128] permitted to do abortions in an outpatient setting up to 12 weeks gestation.

A. If it were not for the ordinance which prohibited providing second trimester procedures in the clinic setting, would you provide second trimester procedures to women requesting them?

A. Yes, our physicians would.

* * *

[134] Q. Now, referring to Plaintiff's Exhibit 26, would you explain the purpose of this form, Ms. Goldberger?

A. This form states very clearly the policy of our clinic. That is, that we do encourage minors to inform [135] their parents about the procedure.

If the minor says that she cannot tell her parents, then we want her to write out the reason why she does not

feel she can talk to her parents about this, and she is told in writing that, should there be a medical complication, her parents would be notified.

This is very helpful for our doctors to read before they start discussing with the minor her decision for having the abortion.

Q. So, what you are saying is that these forms—that is, if you have a patient who is under the age of 18, this form is provided?

A. Yes.

Q. And is the form then provided, read by the doctor?

A. Yes, and by the counselor as well. This also will be a guide for the counselor in her approach to talking over the situation with the client.

Q. At what point is this provided to the physician?

A. This form is included in the medical chart and it is provided at the time that the doctor sees the patient.

* * *

[138] Q. Then, if you would describe, please, the procedures that are followed by the physician at that point.

A. Surely. The doctor first reads the medical chart and pays particular attention to whether she signed the consent form.

If she is a minor, he pays attention to what she has said on the minor consent form.

Then he will do—he might review some medical history questions with her before he does the pelvic.

He will do the pelvic examination and he might then review some more medical history if, for example, he finds a scar on her abdomen.

After he does the pelvic exam, he will then ask her if she has any questions and if she wants him to proceed and do the abortion.

If she has questions, he will spend the time and answer the questions.

If she says, "Go ahead and do the abortion," then he proceeds and does the abortion.

Q. Is each patient always asked specifically by the physician, following the physical exam and before the procedure?

[139] ***The Court:*** She can only testify as to the ones she has been there on. You are asking does he do it all the time.

On the occasion when you have been present.

The Witness: When I have been present, the doctor has always asked, "Do you want me to proceed and do the abortion?"

Unless the patient says, "I hope you can do the abortion; I want you to do the abortion"—if the patient voluntarily, as soon as he walks in, says, "Please, do it as soon as possible; do it," then that is the only occasion where he does not then ask her again.

* * *

[140] Q. Now, the waiting period required under the ordinance pursuant to this section would be 24 hours from the time of the informed consent and the informed consent under .06, if you will look at that section, must be provided by the patient's attending physician.

[141] Have you discussed with your physicians the impact or the consequences of the requirement of the attending physician to provide this, these statements, to the patient 24 hours before that same physician performs the abortion?

A. Yes, I have.

* * *

Q. Ms. Goldberger, you mentioned that there are four physicians providing procedures at your clinic. Is that correct?

A. That is correct.

Q. You mentioned that the procedures are provided on three days of the week.

[142] A. That is correct.

The Court: And further, there is just one there at a time; is that correct?

The Witness: That is correct.

By Ms. Roberts:

Q. And is there a reason why there is only one physician there on a given day?

A. Our doctors have full private practices and they can only give us a certain amount of time per week. It is adequate to have one physician at the clinic on a clinic day.

Q. What is the time that is given to the clinic or provided to the clinic for medical services by each doctor per week?

A. Approximately six or seven hours by each physician.

Q. Which would be one day for each physician?

A. Typically.

Q. Under the ordinance, the requirement that the attending physician give the statements required under the informed consent provision to the patient at least 24 hours before he performs the procedure—would that

require that a physician be at the clinic more than one day a week?

* * *

[143] ***The Witness:*** Well, it would require the doctor to be present more than once.

* * *

Q. If your physicians would be required to spend more than one day per week at the clinic in order to conform to the requirements of the ordinance, what would be the impact of that on the clinic?

A. They may choose not to do so, and in which case the [144] clinic would close or alternatively, they may decide only to do it for a fee, in which case we would have to raise our fees.

* * *

[***Cross-Examination by Mr. Dandrea:***]

[156] Q. Currently, what are your procedure days?

A. Wednesday afternoon, Wednesday evening, Friday and Saturday.

Q. Not Tuesday?

A. Tuesday is our day that we use if we have a volume of patients that warrants an extra day opening.

* * *

[162] Q. May I ask whether or not any attempt was made to engage a local physician?

A. Yes.

Q. As an extra doctor to put on for these procedures in January?

A. Yes.

[163] Q. Was that successful?

A. No, it was not.

Q. The local physicians apparently were not interested?

A. I asked the clinic's Medical Director to find a local physician who would be interested. He came back and said, after making inquiries, he could not.

* * *

[*Cross-Examination by Mr. Destro:*]

[183] Q. How many minors, to your recollection, come in with their parents when they come in?

A. Very few of the 17-year-olds and most of the under-17-year-olds.

* * *

[184] Q. Did that minor or have those minors, to your best recollection, told you that they have advised their parents?

A. Some minors have said that, yes.

Q. The others, I take it, then, have put down a reason why they cannot tell their parents; is that correct?

A. That is correct.

Q. Do you discuss that reason with the minor?

A. When it is not too distressful, yes.

Q. What criteria do you use to determine whether or not such discussion would be distressful to the minor?

A. If I feel it would not contribute to her feeling of well-being at the clinic and her feeling of well-being [185] with the decision, then this is not a topic that is brought up.

As an example, if she is telling me that her parents are both dying in the hospital of cancer, then it is not relevant to talk about this.

Q. Has that happened, in your experience?

A. Yes. Usually not both parents, but where the child has only one parent who is remaining and that one parent is terminally ill.

Q. I believe you stated on questioning by Mr. Dandrea that generally patients come to the clinic having made their decision; is that correct?

A. Correct.

Q. Would this also hold true for minors aged 17 and under?

A. Yes.

Q. Would it also hold true for minors under 15?

A. Yes.

* * *

[189] Q. In your experience, Ms. Goldberger, do the minors which you have seen or did the minors which you have seen under age 15 have the capability, in your judgment, of making an informed consent to undergoing an abortion procedure?

A. Yes.

Q. On what basis do you judge this capability; what criteria did you focus in on in determining that?

A. On their ability to state the benefits of not being [190] pregnant in their life and the disadvantages of continuing the pregnancy in their life, in their circumstances.

* * *

[193] Q. Did any of them, to the best of your recollection, change their mind?

A. There have been several occasions where minors came in and, on the day of the abortion, told us that they were being coerced into the abortion by their parents and did not want to have the abortion.

So, we sent them home after sitting down and counseling with them to find that they would then return in two or three days to say that it really was their idea and [194] they really did want to have the abortion after all.

* * *

TRANSCRIPT EXCERPTS OF ALAN G. SEGEDY

VOLUME II

[*Direct Examination by Mr. Hawley:*]

[228] * * *

Q. Prior to drafting Plaintiff's Exhibit 42, Mr. Segedy, had you visited any of the Akron abortion clinics?

* * *

The Witness: No.

By Mr. Hawley:

Q. Prior to drafting Plaintiff's Exhibit 42, Mr. Segedy, had you seen any statistics regarding parental involvement in a minor's decision at Akron clinics regarding their daughter's decision to have an abortion?

* * *

[229] *The Witness:* From the Akron clinics?

By Mr. Hawley:

Q. From anyone who purported to represent the facts at the Akron clinics.

A. No.

Q. Prior to drafting Plaintiff's Exhibit 42, I will ask this question in two parts, one, prior to your drafting 42 and, secondly, prior to the passage of the ordinance in late February, 1978.

Had you seen the informed consent material which any of the Akron clinics provide to their patients?

* * *

[230] *The Witness:* No.

By Mr. Hawley:

Q. Either prior to your drafting of Plaintiff's Exhibit 42, Mr. Segedy, or prior to the passage of the final

version of the ordinance in late Febraury, 1978, had you seen any of these statistics on complication rates at any of the clinics in Akron?

A. No.

* * *

[*Cross-Examination by Mr. Bickett:*]

[248] Q. Mr. Segedy, the work sessions which you referred to attending of the Health and Social Service Committees, other than the four major public hearings, were they open to the public, if you recall?

A. I don't think the issue came up, but I would say no.

* * *

[251] Q. Regarding those work sessions at the Health and Social Service Committee, Mr. Segedy, who else do you recall being present, other than Council members or other public employees of the City of Akron?

A. Marvin Weinberger.

Q. Anyone else?

A. That is all I recall.

* * *

TRANSCRIPT EXCERPTS OF STARLETT C. HURST

VOLUME III

[*Cross-Examination by Mr. Dandrea:*]

[36] Q. He is not a native of this country; is that correct?

A. No.

Q. Has anyone ever complained to you that they could not understand the doctor?

A. Occasionally, they have.

* * *

[39] Q. The question is: At some point, you or someone at your clinic administers Valium to the patient?

A. The nurse administers the Valium after the counseling session.

Q. And before the patient sees the doctor?

A. Correct.

* * *

TRANSCRIPT EXCERPTS OF YVONNE BOLITHO

VOLUME III

[*Direct Examination by Ms. Roberts:*]

[61] * * *

Q. What is your educational background, Miss Bolitho?

A. My background? I was graduated from Mount Union College, 1967, with a Bachelor's degree majoring in psychology and sociology. I have attended Kent State [62] University and Akron University for additional course work. I have taken additional training in counseling and counseling education over the years, so to speak.

I am a certified rehabilitation counselor. This is a national certification that I have.

Q. And these—beyond your undergraduate degree, the additional course work that you have done, would that be on a postgraduate level?

A. Yes.

Q. Miss Bolitho, how long have you been employed at Akron Center as the Director of Counseling?

A. I have been employed there since December of 1976.

Q. And prior to that, what was your employment?

A. I was employed at the Goodwill Rehabilitation Center in Canton, Ohio, as the Director of Vocational Rehabilitation Services for a period of eight years.

Q. And what kind of employment experience did that involve?

A. Okay. As the Director of that program, I was responsible for the hiring and supervision of approximately 12 to 14 other professional people, the running

of a dormitory residential program for people involved, clients involved, in that particular program, and the general oversee of that particular program in general.

Q. Miss Bolitho, the residential program that you [63] described, what age groups did this include?

A. Primarily the majority of the people in residence would be between the ages of, say 16 and early 20's—up to the early 20's.

* * *

[64] Q. Miss Bolitho, as Director of Counseling at Akron Center, you stated that you hire the other counselors?

A. That is correct.

Q. Are there specific standards that you use to determine the qualifications of a counsel for your clinic?

A. Yes. I do have particular standards. My requirement is that a person have at least a four-year college degree and experience in family planning in the family planning field.

Q. How many counselors are under your supervision now?

A. Two other counselors.

Q. Would you describe their educational background?

A. Yes. One of my counselors is a graduate from Kent State University in the Allied Health Sciences Program with considerable background and experience in sex education, having worked with the Army in doing sex education at various base hospitals.

My other counselor is currently in a graduate level program at Kent State in counseling and education. She [65] also has experience in family planning through one of the planned parenthood associations in southern Ohio.

Q. And they both have undergraduate degrees?

A. Yes, they do.

Q. Does either of the counselors have a Master's degree?

A. One of them has a Master's degree, and the other one is working on her Master's degree.

Q. Now, in addition to the requirements of education, what other factors are involved in your consideration and selection of counselors?

A. Okay. Certainly the educational background is important. I am also looking for someone who is knowledgeable about the area of problem pregnancy, who is empathetic to the needs of individual women, and who is sensitive to those needs, so I am looking for people with empathy and sensitivity.

Q. Do you require prior experience in counseling?

A. Yes.

Q. And have the counselors under your direction at Akron Center had prior experience counseling?

A. Yes.

Q. Would you describe that experience?

A. Well, I mean—what I was talking about in terms of both counselors having had experience in doing problem [66] pregnancy counseling and in the area of sex education. One counselor, as I indicated, had worked with the Planned Parenthood Association in southern Ohio, and had experience there for that particular program, and the other counselor had done sex education within the hospital setting through the Army.

So, they have both had experience.

* * *

[67] Q. Now, as a counselor at the Center, do you find that some patients have, before contacting the Center, before coming to you for counseling, been counseled by someone else prior to coming to the Center?

[68] A. Yes, we do. I would say that we find approximately two thirds to three fourths of our patients have been seen by other professionals and have been counseled before they come to us.

Q. And under what circumstances would these people have—would these women have discussed these matters with other counselors?

A. Okay. Primarily, they would have discussed, I think, the issue of pregnancy—of an unwanted pregnancy with the people that would have referred them to our agency, which might have been their private physician. It may have been their school guidance counselor. It may have been one of the counseling staff from another social service agency such as a family planning agency, whatever, that would have referred them to us.

Q. Do most of your patients come by referral from another agency or physician?

A. The majority of our patients come to us by referral, which would include social service agencies and private physicians.

Q. Can you estimate how many, what percentage, if you know?

A. Come to us by referral?

Q. That is right.

A. I would say 65 to 75 percent.

* * *

[69] Q. Now, you mentioned that the majority of patients are referred by either physicians or social service

agencies. Now, would this be true to the same extent with younger patients, that is patients under the age of 15?

A. Yes. In fact, probably more true.

Q. So the patient under the age of 15 would, for the most part, have already had prior counseling before coming to the Center?

A. Most likely, yes.

* * *

[72] Q. Miss Bolitho, have you counseled women at the Center seeking abortions who are under the age of 15?

A. Yes, a few.

Q. And are they usually accompanied by their parents?

A. Under the age of 15, yes, usually.

Q. Have there been occasions when they have not been accompanied?

A. Yes, there have been.

Q. And in those situations, do you inquire if they have told their parents?

A. Yes, we do inquire. We specifically inquire.

Q. If the young woman says, "No, I didn't tell them," [73] do you inquire—do you encourage her to tell her parents?

A. Yes, I do. I do encourage her to tell her parents. I also—if she says her parents don't know, I try to find out why they don't know, why she hasn't talked with, you know, at least one parent, try to find out why they don't know and try to talk with them about ways in which they might approach their parents.

I think that probably in some circumstances part of the issue is not knowing how to approach a parent. So, that is one of the things that I might do.

Q. If you get a young woman under the age of 15, who has not told her parents—

A. Um-hum.

Q. —and after your encouragement to tell them, absolutely refuses or says she can't, do you inquire about the reasons that she feels that she doesn't want to or cannot tell them?

A. Yes, I do inquire about the reasons. Sometimes those circumstances for why she won't can be pretty important to know.

Q. What are some of those reasons?

A. I am thinking in particular of two situations that I happen to know of personally of young women who had been physically abused, and their fear, their concern was that [74] additional physical abuse would occur if the parents were knowledgeable of the abortion.

* * *

Q. Miss Bolitho, in a situation like that where the young woman tells you her parents don't know, that she feels she can't tell them, do you ever notify the parents anyway?

A. No, I do not.

* * *

[*Cross-Examination by Mr. Bickett;*]

[76] Q. To your own knowledge, or within your own knowledge, does the patient ever receive medication of any type at your clinic prior to seeing the doctor?

A. Medication prior to seeing the doctor?

Q. Yes.

A. Occasionally.

[77] Q. And what type of medication would that be?

A. If a patient requests a mild tranquilizer, they might be given a mild tranquilizer by the doctor.

Q. Would this request ever mean that a tranquilizer would be given before counseling?

A. No, that is probably where the request might occur. That is probably when the person would make that request, but they wouldn't get the medication at that time. They wouldn't get it until later.

* * *

[84] Q. When you learn of prior physical abuse to a minor, do you report that fact to the doctor at your clinic?

A. In those particular instances, because we did know of it, that information was given to the doctor, yes.

Q. How does that information get to the doctor, as a matter of policy?

A. Well, as a matter of policy, the counselor would tell the doctor that.

Q. In other words, does it always happen that when a clinic learns of physical abuse to a minor, that information is always communicated to the doctor?

A. Yes, yes.

Q. Is it communicated to anyone else, that fact, either within or outside the clinic?

A. It might be. It might be reported to the clinic Director.

Q. As a matter of policy, is it reported to the clinic Director?

A. No.

Q. As a matter of policy, is it reported to any social agency?

A. Not as a matter of policy.

* * *

[88] Q. Yes. To your knowledge, has a minor ever received only group counseling before she had an abortion?

A. Yes.

* * *

The Court: Only group counseling. Minors. Is that normally the case?

The Witness: No. I would say probably, in a situation of a young minor, that would not normally be the case. She would probably receive both.

* * *

[92] ***The Court:*** What is the policy of selecting when other people are brought in?

The Witness: The policy would be that other members of the group would have to okay that. They would have to agree that is all right for this particular person to bring her mother or her sister or aunt or whatever.

* * *

TRANSCRIPT EXCERPTS OF DR. ADELE HOFMANN

VOLUME III

[*Direct Examination by Mr. Landsman:*]

[103] * * *

Q. Are you licensed to practice medicine in any states?

A. I am licensed to practice medicine in both New York and Connecticut.

Q. Are you Board certified in any specialty?

A. I am Board certified in pediatrics.

Q. Is there any subspecialty?

A. I have a specific commitment to adolescent medicine and I am full-time involved in that field.

Q. Have you written any articles or publications in that field?

A. I have written a number of books and a number of articles in the area of adolescent health care, adolescent sexuality, in counseling adolescents, and a variety of aspects of that sort, yes.

Q. Doctor, are you a member of any learned societies?

A. I am a member of a number of societies. I think the ones that are particularly relevant here are the Society [104] for Adolescent Medicine and the American Academy of Pediatrics.

* * *

Q. What is your present employment?

A. I am presently—my functional title is Director of the Adolescent Medical Unit, New York University Medical Center, Bellevue Hospital.

My academic title is Associate Professor of Pediatrics, New York Pediatric Medical School.

* * *

[107] Q. Do you feel that termination of teenage pregnancies by abortion is a valuable medical option?

A. It is an essential medical option in my opinion. We see so many young people whose lives are virtually destroyed by having to go to term, if this is not what they would like to do, both medically and emotionally and socially, and it would be devastating to us now to have [108] to return to the time when this was not an available option.

Q. At what stage in their pregnancy do adolescents generally, not in your clinic, but generally avail themselves of medical care when they are pregnant?

A. I think it is a universal experience that the teenagers come to traditional health care systems extremely late in their pregnancies, generally well on into the second trimester.

Usually, at that time when this is a matter which neither they nor anyone else can deny because pregnancy becomes obvious.

Q. Have they, in those cases you have described, seen other physicians or gotten other care before they come in?

A. No.

* * *

[109] Q. Why are adolescents so slow to seek medical assistance in their pregnancies?

A. We have a society which still views a pregnant, unmarried youngster as a so damaging social issue. There is a tremendous amount of social pressure upon her to publicly declare this or even to herself to recognize it.

She often has a great deal of conflict in her own mind over it. It is an enormous conflict in the family in which the parents may have been raising her on a standard of premarital chastity and which she isn't able to live by that and becomes pregnant.

It is a horrendous conflict of how to tell your parents, so all of these pressures, the social, the inner, [110] the parental fears and concerns really provide a provocative barrier to her to admit to this need and do something about it.

Q. Is pregnancy the only area in which teens are slow to seek medical assistance?

A. I would say this is true of any number of a variety of sensitive health issues or sensitive situations. The argument is equally applicable to young people who have problems with drug abuse, to young people who have mental health problems, particularly when the major conflict is in relation to their families.

* * *

[112] Q. What is your general attitude toward parental involvement in the provision of medical services to adolescents?

A. I am committed to the fact that parents are the best supporters and best allies of their adolescent children and should very much be involved if it is at all possible.

[113] Q. Are there ever occasions when that parental involvement is inappropriate?

A. There are times when the situation at home is such for one of a variety of reasons where it can be harmful.

* * *

[114] Q. Would it ever pose a threat to the physical well-being of an adolescent to notify her parents over her objection?

A. There are a number of ways in which that is possible and indeed has happened. The first is that the advisement that parents must be notified may well precipitate elopement.

One I have seen happen is that the young person runs away.

Q. Elopement from what?

A. Running away from home and from medical care, both. [115] I have seen that happen.

The second area where this may occur is the fact that I have also seen parents beat the heck out of their kids on being told that they were pregnant. We have had several instances in which there has been severe corporal physical punishment inflicted upon the adolescent.

A third I know is the recognized high association in certain selected youngsters of pregnancy with suicide attempts. We don't have the data on suicide completion and usually we are able to stop it from completion, but there is a definite correlation and the requirement and any additional barriers placed into giving her support moving in to meet her needs and the argument that may obtain to parent notification between her may often be the crisis precipitating suicide attempt.

Q. Do you ever find it to be a threat to an adolescent's emotional well-being to notify her parents over her objection?

A. I think that in many ways that it creates a tremendous amount of anxiety in her mind, a feeling of people's—not lack of trust.

* * *

[116] Q. Would notification ever pose a threat to continuation of the family relationship, the family structure?

A. In some instances, and particularly those where there are major variations in the moral value system.

* * *

Q. If parents of all 15 to 17 years old, of adolescents, knew of their daughter's decision to seek abortion, what role will the parents thereafter play in the abortion decision process?

A. This was notification?

Q. Yes, notification, Doctor.

A. There is really so little difference between notification and consent as the minor is concerned. It is a technical issue, both of which require parents' knowledge and that is what the young person is concerned about.

[117] Once a parent knows about the issue, whether through notification or consent, the parent then can exert a force in terms of how that adolescent is going to respond to that pregnancy. It is extremely difficult and, I think, very hard for a 15-year-older who wishes to go into one course to go against her family's wishes once they have been notified.

How can a person 15 years old, whose parents want her to go to term, say, "No, I don't want to"? It is very difficult for young people to bring these adversary practices into their families and it doesn't really belong there.

Q. Faced with the prospect of parental notification, what is the pregnant adolescent likely to do concerning the abortion decision?

A. I think it is very simple. It is going to be just what happened before when we weren't able to give her confidential entry into the care, and that is delay it.

Q. What, if any, health risks are there in that response?

A. The health risks are those I have enumerated before of the increased risk to her really going so late that she would not have the option of abortion and will be forced into going to term, and that is inherent health risks that we have discussed of toxemia, anemia, [118] prematurity in the baby and so on.

Q. Would a requirement of parental notification in every case in which an adolescent elects to have an abortion create any problems for the physician in her practice of her profession?

A. I guess from my perspective, I feel it is somebody telling me how to do my business. It really ties my hands in such a way that I can't do things in a flexible manner which is suited to the individual instance.

I would say that I certainly make every effort in any instance to explore and discuss with the teenager who is pregnant the feasibility and even desirability of involving her parents if she can.

To have this as a required mandate puts me in the position of compromising my development of a trust relationship by bringing kinds of external requirements into the intimacy and privacy of the patient-physician relationship and the way in which I may be able to help her for effective negotiations rather than a kind of an impersonal notification to the parent.

* * *

[119] Q. Is an adolescent capable of making an informed decision concerning whether to have an abortion without parent input?

A. Some adolescents are able very easily to give a decision. I think most adolescents can, with some professional guidance, come to a rational and reasonable decision.

Q. At what age can adolescents manage this decision?

A. Well, there is a developmental concept that has been introduced by a widely recognized theoretician of Jean Piaget in France.

His experience and research demonstrate that young people come to the capacity of abstract thinking, that is [120] an ability to take an experience here and now and look down the road at the future and perceive how this will affect them and to begin to appreciate those kinds of concerns and, to my estimate, that is what is essential; we have found essential for the capacity to give informed consent.

People begin to come to this at 12, approximately, as a wide variation, and generally the capacity for—developmental capacity for abstract and rational thought is fully achieved by 15, so that it is developing very nicely in 13, 14 and 15 and certainly most 15 to 16-year-olds really have the capacity to give an informed consent on the developmental basis.

* * *

All this means the greater the risk of prematurity for the young teenagers. I very frankly tend to feel fairly pro abortion for the very young teenager. It is an unknown quantity versus a young person whose life has not yet even begun to be fulfilled, and I really have to say that maybe we should be encouraging these young people a little more to think of abortion in a rational way.

* * *

[122] Q. * * * Doctor, with respect to parent consent, do parents ever withhold approval for medical procedures which are in the best interest of the children?

A. This occurs with some frequency. Classic is the one, I am sure, that you and everyone else is familiar

with, the instance of Jehovah's Witnesses who refuse to allow blood transfusions that are necessary for saving the life of their child.

Q. Now, does this kind of situation ever arise in the abortion context?

A. It does indeed. We have many instances, as do other people involved, where the young person wants an abortion and my experience extends back into the 1960's, [123] having entered the field in 1963, when abortion was not a consideration at all, and then somewhat later where the parents consent issue was much more rigidly applied than it is today, and there were many young people who were not allowed to have this as an option because their parents would not consent.

Q. Faced with the prospect of parent consent in all cases, say those in which judicial consent were substituted, what is the young adolescent 14 years or younger likely to do concerning the abortion decision?

A. I think she will just delay entry into care until again her pregnancy is very well advanced. The particular young adolescent is typically prone to denial and avoidance of difficulty and anxiety-producing situations, so she simply will not enter into the health care system until fairly late in the pregnancy.

Q. Are the risks you detailed previously with relation to delay applicable here?

A. Even more so for the young adolescent.

Q. Would a requirement of parent consent in all cases, save those that have been excepted, cause any problems for you as a physician in rendering health care to young adolescents?

A. They pose an additional barrier to the exercise of a rational, reasonable approach towards the young person

[124] and their family. They are handcuffs, in essence.

* * *

Q. Would a consent requirement of the sort I have described pose any health threat, either emotional or physical, to a young adolescent 14 or younger?

A. This major barrier is, of course, if a young person [125] knows that they have to have their parents' consent, they simply will not come for care in the first place and, again, this will cause late entry into care and if the parents refuse to permit abortion, it deprives the young person of an option that might really be in their best benefit.

Q. Doctor, if you would examine Section 1870.05(B)(1) with the question in mind: What effect will that have on the health ca and health needs of the adolescent, young adolescent?

* * *

The Witness: Well, this is the specific format in which I, as a physician, would have to operate, and my major question here—and I have addressed the issue of what a consent requirement would obtain—but what would concern me here is how to implement it.

I have had experience in requiring written consent of parents and we have a [126] number of options.

One, we could give the young person a written consent form to take home with her to have it signed. She has three choices. She can throw it away if she walks out and not come back. She can go to her parents and have the parents sign it, which I have already spoken I think it is difficult for a young person to do, or, thirdly, she can forge the signature. We find this happens, and I really dislike very much being placed in a position of encouraging duplicity when I am trying to create honesty and openness.

Another option would be, say, "Go bring your mother in," or have somebody go to the home with the declaration saying, "Sign it." The technique of doing this obviously places an enormous burden in terms of how do you do it.

Parental notification on the signed form the kid takes that is notarized also poses very difficult problems not only for the parent, but for the youngster who can't ask her parents, and for many parents for whom finding a notary becomes a real problem. [127] Inner city parents who have to pay $2 sometimes just isn't done.

So, it becomes technically, and I have considerable direct experience with that, very difficult to implement in the practical way.

* * *

[128] Q. Turn your attention, if you would, Doctor, to the third aspect of 1870.05, that is judicial consent.

Faced with the prospect of judicial consent, providing of course you can obtain parent consent, what is a 14-year-old or younger adolescent likely to do about the abortion decision?

A. Well, at first glance, it really poses an impossible burden. Most young people, in terms of perceiving the judicial system is not that of being their ally. The contact of most young people with the judicial system is in terms of having infracted various rules and regulations.

Secondly, how do they gain access to the judicial process? Perhaps one might say this would be in and of the health care provider, but then this poses enormous [129] problems for the health care provider to have access to the court system.

* * *

Q. Are the medical risks you detailed before applicable in the context where you got this judicial consent procedure in place?

A. I think it perhaps would be even more difficult for a youngster to how they would negotiate a judicial process as a barrier. It adds to what I think this piece of legislation is, an enormous set of cumulative barriers to young people gaining access and going through with needed health care.

Q. Would the judicial procedure I described create any problems for the physician in her practice?

A. It again, from my perspective, does intervene with the therapeutic role that I can play with the patient and [130] their parent by introducing another cumbersome set of regulations that I have to observe in a rigid way and deprives me of the flexibility that I really very much need in this instance.

Q. What effect would such a proceeding have on the relationship between the parent and the young adolescent if the proceeding were to go forward?

A. You know, we have a tough enough time with parents and adolescents in helping them to negotiate communications, and if you introduce an adversarial process where the young person is challenging the parents' right to determine their fate, I think this is really a rather unfortunate state of affairs, to put it mildly.

Q. Will 1870.05(B)(2) of Plaintiff's Exhibit 44 before you have the effects you have described concerning judicial consent?

A. In my opinion, it will.

* * *

[131] Q. Do those varying backgrounds always have to include medical expertise?

A. Well, to be honest with you, I think that probably the physician, in his preoccupation with organic needs, is probably the least well equipped of professional and paraprofessional persons to deal with counseling effectively.

Q. Should the counseling be selected on the basis of formal classroom kinds of education?

A. Well, as we really haven't really developed any standards and we have some, but relatively few formal [132] programs, and as I think, experience has demonstrated that there are a lot of people who can develop counseling skills in in-service training programs, my answer would be no.

I think there is one prerequisite, and the prerequisite can extend for a person of whether there is a peer counselor or whether there is an adult counselor, whether there is an adult who is an indigenous adult to the community, the one requirement is that, in my perspective, is that they have an ability to relate to young people and feel comfortable with them.

* * *

[*Cross-Examination by Mr. Bickett:*]

[140] Q. Where do you refer the patients for the actual [141] abortion procedure? What type of facility, not necessarily the name?

A. We generally refer them to the established clinics in the community. We find that the hospital-based facilities are very generally poor, very insensitive, and particularly, I regret my confreres in my own institution are relatively insensitive to adolescent needs and that the very best of counseling and support systems are available in the free-standing clinics, the free-standing abortion clinics, okay?

* * *

TRANSCRIPT EXCERPTS OF MARCIA M. PARKER

VOLUME III

[*Direct Examination by Ms. Roberts:*]

[183] * * *

Q. Miss Parker, are you employed?

A. Yes, I am.

Q. Where are you employed?

A. At Planned Parenthood of Stark County.

* * *

[187] Q. Miss Parker, will you describe your duties and responsibilities at Planned Parenthood as a counselor and educator?

A. I do the counseling in family planning.

* * *

[189] Q. Now, again, specifically with respect to young women under the age of 15, is a parent usually with a young woman of this age?

A. A parent or a relative usually accompanies the person.

Q. Then, in those cases, is that parent or relative also part of the counseling process with respect to the decision to terminate the pregnancy?

A. Yes, they are.

Q. Now, if the decision is made to terminate the pregnancy, following the counseling, then do you make the referral to an agency for that termination?

A. I do make the referral to the person and that they must call the agency of their own accord.

[190] Q. Do you typically refer your clients to facilities in Akron for the termination of their pregnancy?

A. Yes, I do.

Q. What specific facilities in Akron do you refer your clients to for abortions?

A. The Akron Center for Reproductive Health, because they are a nonprofit clinic, and Akron Women's Clinic.

Q. And Akron Women's Clinic is profit or nonprofit?

A. As far as I know, it is a profit organization.

Q. But you nevertheless refer them to that agency?

A. Yes, we do.

Q. Miss Parker, who selects the facilities for those referrals?

A. Okay. That is done by an evaluation process of Planned Parenthood.

* * *

[194] Q. Miss Parker, were you a part of the evaluation of those facilities?

A. Yes.

Q. And so you participated in those evaluations?

A. Yes.

Q. Did the evaluations include a visit to the facilities themselves?

A. Yes, they did on procedure days.

Q. And what did that visit—strike that.

What did that evaluation involve, that is, what was reviewed during that evaluation?

A. Specifically, the counseling sessions, the qualifications of the staff, whether or not the guidelines were being met as far as the content of the counseling sessions meaning the description of the procedure, the offering

of birth control information, and as far as the medical staff is concerned, the medical equipment that is used, emergency equipment, et cetera, and the qualifications of the doctors and the nursing staff.

* * *

TRANSCRIPT EXCERPTS OF REGINALD K. BROOKS

VOLUME III

[*Direct Examination by Ms. Leitzer:*]

[213] * * *

Q. And please state your current employment.

A. I am an Akron City schoolteacher, curriculum aid specialist. I am an instructor at the University of Akron in the evening college, and I am also an Akron City [214] Councilman.

Q. How long have you lived in Akron?

A. I am a native Akronite.

Q. How long have you served on the City Council?

A. I am in my third year, second term.

Q. Now, could you describe the procedure for introducing legislation into the City Council and its passage through the Council through enactment?

* * *

The Witness: Yes. Normally, a person will sponsor a particular ordinance. He will go into the City Law Department, sit down with the Law Clerk, discuss his idea, what the intent of the law is supposed to do, what the problem is, and at that time, the Clerk will draft the legislation into formal legal terminology.

At that point, it will be sent to City Council, read into the minutes of the meeting, and referred to committee for hearings whereby, at that point, the proposed legislation will [215] undergo the scrutiny of that particular committee charged with the responsibility in that particular are.

They will make a recommendation to the City Council as a whole on the floor when it is introduced, and we will vote on it at that point.

By Ms. Leitzer:

Q. Does the committee ever redraft an ordinance?

A. Sometimes it is sent back and revisions are made.

Q. By who?

A. Usually they are made by the members of the committee. Sometimes deletions are made. Sometimes additions are made, and then it is sent back.

Q. Now, does that redrafting process usually involve members of the committee alone?

A. Sometimes it does. Most of the time it does. Sometimes on a very controversial issue, it involves all of the City Council.

Q. Does it ever include outside interest groups?

A. Yes, we do take testimony from various segments of the community that would have an interest in that particular legislation.

Q. But would those outside interest groups and individuals involved in those groups ever sit down with the [216] subcommittee at a working session and assist in the actual physical redrafting?

A. I have never seen that done before.

Mr. Bickett: Your Honor, I am going to object.

The Court: Objection sustained. I don't understand. You mean is that ever the practice or is there any rule saying they can't do such a thing?

The Witness: I have never seen it done before.

The Court: All right. In other words, that is the normal practice that it is not done, but there is no rule of Council saying you can't do it?

The Witness: There is no rule that I know of, but I have never seen it done.

The Court: Okay, fine.

By Ms. Leitzer:

Q. Now, are bills ever introduced into Council that have not been written by the City Law Department?

A. In my experience in three years, I have only seen two and one was rejected at face value. The other one was this particular ordinance.

Q. Why was—could you explain the circumstances [217] around the other one?

* * *

The Witness: Normally, we don't like to bypass our own Legal Department to have the language correct with our own City Code. We like to have it drafted in the proper format.

By Ms. Letizer:

Q. Could you explain what other ordinance, other than the abortion one—I take it that is what you were referring to—that was rejected at face value? What was it? Who wrote it and when was that?

A. To my recollection, it was an ordinance dealing with establishing a home for pregnant women.

Q. When was that introduced?

A. Just recently. Maybe two months ago.

Q. And why was it rejected?

A. Because it had not come through the proper channels and we felt that we didn't want to depart from past procedures and we sent it back with the recommendation that it go through the proper channels.

[218] *Mr. Bickett:* Your Honor, I would object to the use of the term "we."

The Court: Objection sustained as to the opinion of the other 12 members.

By Ms. Leitzer:

Q. All right. When I ask you these questions, I am referring to your perception, your knowledge.

A. I understand. Okay.

Q. Now, did you and other City Council members receive any abortion-related literature prior to the introduction of the abortion ordinance?

A. Yes. We were inundated by this literature long before we even had mention or heard mention of a pending ordinance.

Q. About how long before?

A. Two to three months ahead of time.

Q. And was there any pending abortion legislation at that time?

A. No, there wasn't.

Q. Is it usual for Council members to be inundated with literature regarding an issue when there is no pending issue?

* * *

[220] ***The Witness:*** Generally. I characterize that by saying that that is what we call lobbying, and normally, that is not done until an actual piece of legislation is introduced. Then, at that time, the lobbying efforts, those for and those against, usually begins, but I have never seen it ahead of time.

* * *

Q. How would you characterize the mail that you [221] received?

A. The mail that I received was pushing or promoting

the idea that abortion was immoral and that it was heavily shaded with Biblical quotations.

Q. Did this flow of literature regarding abortion literature of this nature continue after introduction of the ordinance?

A. It became more intense. . . .

* * *

[223] Q. Do you recall if there was any evidence at those hearings regarding the informed consent practices at the clinics?

A. To my knowledge—are you speaking of here in Akron?

Q. Right, the clinics in Akron.

A. No.

* * *

Q. Did you oppose the ordinance?

* * *

[224] ***The Witness:*** Yes, I did oppose it.

By Ms. Leitzer:

Q. Why did you oppose it?

* * *

The Witness: First of all, I have certain misgivings about abortions myself, but I opposed it largely based on the testimony that was given during the public hearings by the Law Department and the Health Director and the Director of Summit County Public Health Society.

* * *

[225] Q. In opposing the ordinance, did you take into account the recommendations of the City law department?

A. I suppose that was the biggest thing that swayed me. I had certain ambivalent feelings about abortion, as

I said, but being a teacher and teaching constitutional functions and government, I don't believe I have a right to impose my view of morality on other people. It is a rather personal—

Q. What were Mr. Spicer's objections to the ordinance?

* * *

[226] ***The Witness:*** In two occasions during the committee hearings, Mr. Spicer indicated that he would like to be withdrawn from the case and that he felt that it was his opinion that the legislation, as drafted, was unconstitutional and indefensible, and he recommended that we not act on it.

* * *

[227] Q. Now, is there any other time when a City attorney has made a similar recommendation regarding a proposed ordinance that the Council disregarded that advice and went ahead and enacted the ordinance?

* * *

[228] Q. In your experience.

A. I had never seen it.

The Court: How long has Mr. Spicer been over there? He left here what, eight months ago?

By Ms. Leitzer:

Q. Either Mr. Spicer—I am sorry—or another City attorney who was asked advice.

A. Basically, we rely on their opinions and we go along with them, unless there is some overriding reason, but I, in my three years, have never seen it done before. It may have been done, but I have never seen it.

* * *

[229] Q. Getting back to the ordinance, what is the procedure that is followed before a vote or final passage

of a bill? In other words, when you come into a committee meeting and you have on the agenda a vote, what is the normal procedure for passage?

A. The committee reads the recommendation, they hold a vote, they take a tally of the votes, and then it is usually discussed at a caucus meeting, which is prior to the formal City Council session, and at that time, it is debated back and forth how the votes are going to come out, and then we actually vote on it following the caucus session in the formal Council session.

Q. Do you have, at that time, in the caucus session, a copy of the proposed ordinance?

A. Normally we do, yes.

Q. Did you receive a copy of the final version? Let me hand you Plaintiff's Exhibit 44. Do you recognize that? Can you identify that?

A. Yes. Can I identify it?

Q. Yes. Could you identify it for me.

[230] A. Yes. I did not see the final drafted version of the ordinance until after the vote was taken. I never did have the final copy before me.

Q. Is that a usual procedure that you were asked to vote on something which you had never seen the final draft of?

A. It is very unusual. It has happened before, but it is very unusual, especially on something like this.

The Court: It wasn't available the night of the vote, sir, or the day of the vote?

The Witness: Well, there were several people in Council that had copies, but not everyone had copies of the ordinance.

The Court: Did you object at the time that you hadn't seen a copy of it?

The Witness: Well, I read off of the person that was sitting next to me, and I read off of their copy.

The Court: So you did see a copy of it prior to passage?

The Witness: I saw the face cover of it. I never did—you know, there were some problems during that and some people [231] did object to not having the legislation, but sometimes, when legislation comes in late, like a department head needs something passed right away, we have in the past voted on things rarely that we haven't seen, but we don't like to make it a practice.

The Court: That is on lesser important things?

The Witness: Yes.

The Court: On routine things. I understand.

* * *

TRANSCRIPT EXCERPTS OF HENRY DAVID, PH.D.

VOLUME IV

[*Direct Examination by Mr. Landsman:*]

[57] * * *

Q. Are you a diplomat in any field?

A. Yes, I am, in clinical psychology.

Q. Are you a certified psychologist?

A. Yes, I am certified and licensed in the District of Columbia and the State of Maryland.

Q. Doctor, have you written any scholarly publications?

A. Yes, I have written a number of books and over 150 articles.

Q. What subjects were those on?

A. They range in the area of psychology as well as [58] population.

Q. And have you, in the last five years, sir, concentrated in any area?

A. Yes, the last five years particularly in the population area. In fact, my latest book was only published last week, "Abortion in Psycho-social Perspective Trends and Transnational Research."

* * *

Q. Have you done any consultation groups, sir?

A. Yes, I am currently a consultant in the World Health Organization, both in the headquarters in Geneva and in the European office in Copenhagen.

Q. Have you done any consulting in the United States, [59] sir?

A. Yes. I was one of the consultants to the National Academy of Sciences Institute of Medicine on the study of abortion and the public health.

Q. What is your present employment, sir?

A. I am currently Director of the Transnational Family Research Institute in Bethesda, Maryland, and I also serve as Associate Clinical Professor of Psychology in the Department of Psychiatry in the University of Maryland Medical School, Baltimore.

Q. What is the Transnational Institute, sir?

A. The Transnational Institute is a private, nonprofit, tax-exempt research organization in behavioral sciences and works primarily in the population area.

Q. What experience do you have, sir, in examining questions of psychiatric sequelae or aftermath to abortion, to pregnancy, and to other questions in the area of sexuality?

A. We have conducted studies in this area since about 1970, have published extensively, reviewed other publications, et cetera.

* * *

[60] Q. Doctor, what does the term "psychiatric sequelae" mean?

A. It is a quite diverse term used differently by different people, but I would like to define it here in its operational sense of being admitted to a psychiatric hospital either following term delivery or following abortion.

* * *

[62] Q. Have you reviewed the literature in this area?

A. Yes, we have.

Q. What, in your expert opinion, is the likely psy-

chiatric effect of abortion upon women with existing psychological problems?

A. The general consensus is that such women have often experienced some relief from their particular psychiatric conditions, but I do want to add that there are occasions when a woman continues to have psychiatric problems, but to the best of our knowledge, at this time, the relief far exceeds the number of difficulties.

Q. Upon what is that analysis based, sir?

A. That is based primarily on studies done of psychiatric patients, both in the United States and abroad.

* * *

[63] Q. What is the likely psychological effect of abortion upon women with no pre-existing psychiatric problems?

A. In the majority, vast majority of cases, it is a feeling of relief.

Q. Is the same conclusion true with respect to minors under the age of 18, sir?

A. To the best of our knowledge, it is.

Q. Can you quantify the likely psychiatric effects of abortion on healthy women, sir?

A. Yes. There has only been one—well, let me put it this way. I think one needs to compare post partum cases and post abortion cases. It is the only real comparison control groups that can be conducted.

To the best of our knowledge, there has only been one major study in the United States of post partum psychosis, and the findings there were between 15 and 25 per 10,000 deliveries.

Q. That is post partum?

A. Post partum, yes. In the international literature, it is generally found somewhere between 15 and 20, and that [64] is a figure I would like to propose.

On the other hand, post abortion admissions to psychiatric hospitals, and that is what I am talking about, range between three and four per 10,000 aborters, and if those figures hold up, as we believe they will in Denmark, the incident or the risk of a post partum admission to a psychiatric hospital is about five times as high—four to five times as high as admissions to a psychiatric hospital after abortion.

Q. If you would again, please look at 1870.06(B)(5) with the following question in mind: What is the scientific accuracy of the statement contained therein that abortion can result in severe emotional disturbance?

A. I would say that the scientific accuracy is very limited because it makes no comparisons whatsoever between relief and difficulties, and anyone who says may or can, I do not consider a scientifically valid statement.

Q. Now, Doctor, in answer to one of your prior questions, you indicated that post partum difficulties, after going to term were more significant than those based in abortion. Could you give us those figures again, sir?

A. Yes. I made—I stated the opinion that the risk, the mental health risk, as defined in terms of admission to psychiatric hospitals, is far greater after giving birth than after having had a first trimester abortion.

[65] Q. Now, sir, is that true for minors underneath the age of 18?

A. To the best of our knowledge, it is.

Q. Doctor, on what study is that based?

A. Based primarily on international conferences and discussions with colleagues. I have not been able to separate these out by specific age, but our experience leads us to believe that this is correct.

Q. Now, for the overall conclusion that you have expressed, is there a United States study?

A. There is no United States study except one small—one conducted at Johns Hopkins University reported in 1973 where groups of women at Johns Hopkins University were compared in terms of first trimester abortion, second trimester abortion, and carrying a pregnancy to term.

These women were examined at the time of the event of the procedure with the birth or abortion and follow-up examinations were conducted about one year afterwards.

A whole range of psychological tests were used as well as psychiatric interviews, and the only statistically significant finding to emerge from this study was that women giving birth had a higher score meaning—showing greater disorder on the psychological test and the conclusion drawn from this study was that psychological risks were higher in women carrying to term than women [66] having abortion.

I would like to add to this that these were not definitions in terms of admissions to psychiatric hospitals, but were definitions in terms of psychological test scores.

Q. Now, were these objective type tests?

A. Yes.

Q. Were they tested?

A. The key test used was the Minnesota multi-phasic

inventory, which is a very well standardized, regarded, and widely accepted psychological test.

* * *

[*Cross-Examination by Mr. Umbaugh:*]

[85] Q. You have indicated, I believe, that there is some relief experience by a woman post abortion in your findings; is that correct?

A. Yes.

Q. Would that also be true for a minor?

A. For most minors, yes.

Q. Have your studies indicated whether that relief is a more or less short-term relief, or whether that is a relief of longer duration?

A. Our findings suggest that the relief becomes stronger the further the woman is removed in time from having had the abortion.

In other words, the longer-term effect is much more frequently one of relief.

[88] Q. So your studies now, or some of them did include that factor of parental involvement. Is that your answer?

A. By parental involvement, what do you exactly mean?

Q. What I am referring to is whether or not the parents participated with their minor daughter in the decision as to whether or not to abort?

A. There are examples of cases where a minor did not consult their parents, and there are examples of cases where a minor did.

I find it extremely difficult to make a generalized answer when very often there are very special circumstances in each such case.

Q. Perhaps you can—

A. May I just finish, and I would only say that in the studies that have been done, in nearly every case, the net result was one of relief, regardless of parental [89] involvement.

Q. Regardless of parental involvement?

A. Yes.

Q. If your studies have considered this element, can you tell us what difference parental involvement made, if any, in a minor's resulting relief or psychological problems?

A. Well, I think it goes without saying that any minor who experiences support from parents or any other important person in her life is going to have an easier time.

* * *

[90] ***The Witness:*** The general finding on counseling, and that is the only evidence we have, is that counseling by and large does assist the woman, whether she is a minor or not, but I would want to go back to my previous point, and that is that counseling with minors is important. There is no question of that, but the basic question is: Does the minor—has the minor made a decision?

It is not up to the counselor to make the decision for her. She must be sensitive or he, whoever the counselor is, to the minor's state of mind and if the minor is ambivalent, has not been able to reach a decision, that must be the first perspective.

* * *

[91] Q. Do your studies indicate whether or not a minor who has received counseling prior to making her abortion decision, whether or not that fact of counseling

has any effect on the likelihood of her subsequent either abortion relief from the procedure or complications from the procedure?

A. It is very difficult to answer, because counseling procedures in different abortion clinics are not standardized, but by and large, I think one could only [92] hypothesize that since the incidence of adverse psychiatric sequelae is indeed very, very small, counseling would have to have a positive effect.

* * *

TRANSCRIPT EXCERPTS OF DR. JAY KATZ

VOLUME IV

[*Direct Examination by Mr. Landsman:*]

[96] * * *

Q. Now, Doctor, are you Board certified in any specialty?

A. I am Board certified in psychiatry.

Q. Doctor, do you have any experience in legal matters as well as matters of medicine?

A. Yes. For the last 20 years, I have been on the faculty of the Yale Law School.

Q. Doctor, have you written books, articles and publications, sir?

A. Yes. I have written about 35 articles, including four books on psychoanalysis and law, family law, human experimentation and law and medicine.

Q. Doctor, are you a member of any learned societies?

A. Yes. I was elected two years ago to the Institute of Medicine, which is one of the divisions of the [97] National Academy of Sciences. I am a Fellow of the American Psychiatric Association, American Psychoanalytic Association and many other groups.

Q. Doctor, have you received any outstanding awards which you would like to bring before the Court, sir?

A. Three years ago I received the Isaac Ray Award which is given every year or every other year by the American Psychiatric Association either to a psychiatrist or lawyer for contributions to psychiatry and law.

Q. Doctor, have you undertaken any consultations, sir?

A. I have. I have served on a great many committees. At this point, I am co-chairman of the Connecticut Bar Association Committee on the legal profession and of the American Bar Association of developing a peer review model for lawyers.

I served on the Tuskegee VD-syphilis study appointed by the Secretary of Health, Education and Welfare to look into the experimentation that has gone on for many years with blacks in Alabama and informed consent was a very important aspect of that investigation.

Q. What is your present employment, sir?

A. I am—two thirds of my time I spend as adjunct professor of psychiatry and law at Yale Law School, and one third of my time as training and supervising [98] psychoanalysts of the Western Institute for Psychoanalysis.

* * *

[99] Q. Doctor, have you had a variety of occasions on which to deal with the question of informed consent in your professional work?

A. Yes. Of course, I deal with it constantly in my professional-clinical work and in my consulting work when persons come to see me, asking for information about whether to undergo treatment or not to undergo treatment and for the last 10 years, I have been very much involved in the study of the informed consent process, first in the human experimentation setting and now in both physician-patient and lawyer-client interactions.

Q. Doctor, have you dealt with this topic in the scholarly context as well?

A. Yes. A third of my book on human experimentation is devoted to the informed consent process, and I

am in the process of completing a new case book on disclosure and consent in physician-patient and lawyer-client relationships.

Q. Is that a case book to be used by lawyers and others?

A. Lawyers and medical students, yes.

Q. Where did the idea of informed consent come from? What was the history of its genesis?

* * *

[100] ***The Witness:*** Informed consent is a relatively new doctrine. It was first introduced in a brief opinion in California in *Salgo v. Leland Stanford University Board of Trustees,* where the issue of informed consent was raised for the first time.

It was elaborated upon in great detail in the 1960 opinion, *Natanson v. Kline.* Justice Schroeder, in that opinion, gave the first fairly comprehensive discussion of informed consent, making the point that physicians in the future are under positive duty to make greater disclosure to patients than they had been legally required before, and it was further elaborated in two 1970 opinions, *Canterbury v. Spence,* the opinion of the Washington D.C. Court of Appeals, and *Cobbs v. Grant* of the California Supreme Court.

By Mr. Landsman:

Q. What were the reasons for the genesis of the concept of informed consent in that cusp between medicine and law?

* * *

[101] ***The Witness:*** It increasingly dawned on judges that patients were really very ill-informed about the procedures which physicians recommended them to undertake, and this became particularly clear in the

Natanson v. Kline case where Dr. Kline admitted that he had not given any information to the patient about the serious consequences that might follow a cobalt radiation therapy which was a new therapy at the time, and I think the judges were puzzled to begin with by this behavior and felt that patients had greater rights to information and to participation in the decision-making process.

* * *

[102] Q. As a concept is developed in American medicine and in American law, what is the paradigm of informed consent? Where does this go to? Where is this concept looking?

* * *

The Witness: The paradigm is still very much in a state of development, but I think what the judges are after is to create an atmosphere in which patients have a greater role—have a greater role to play in the medical decision-making process and to gradually begin to define the common law seems to be following in this direction, what are the mutual duties and obligations of physicians and patients in the decision-making process.

* * *

[106] Q. Is there ever a situation when obtaining a patient's informed consent would pose a health risk, sir?

A. Yes, there are situations in which it would. Again, there are studies that seem to indicate that about anywhere from 11 to 17 percent in reported studies of patients [107] do not wish to know a great deal about what is in store for them, and they feel even angry and psychologically traumatized if they are informed and surely, in such situations as acute distress, like myocardial—like heart attacks, when it is important for the patient to be as tranquil as possible to have an extended discussion about consent to various medical

interventions could be detrimental to the patient's welfare.

Q. What techniques and procedures serve to foster informed consent in the exchange between the patient and the physician?

A. I think most important here is the attitude of the physician, namely that he appreciates that the patient is an important participant in the decision-making process.

Q. What would serve to undermine informed consent in situations where it is sought between the patient and the physician, sir?

A. Again, just the other side of the coin of what I have just talked about, bias, prejudice, physician's conviction that only one procedure is indicated and that the patient must choose that procedure, and in the light of all the alternatives available, in a great many medical interventions today, not—and each with its own risks and consequences, not giving a patient an opportunity to have his say in what ought to be done to the [108] patient.

* * *

[110] Q. Now, is the other side of that coin also true that there are times when the physician accedes and should not go further?

A. Exactly.

Q. Now, in terms of frequency of these kinds of situations, in the general context—I know we have sort of been a little specific to abortion, but in the general context, can a physician go ahead once the patient says, "I have heard enough. I know what I want to do. More is not necessary to me"?

A. Sure. In a great many medical situations, it becomes quite clear that the patient wishes to have a

particular procedure performed and that this procedure is [111] professionally indicated, like in an appendectomy and in certain gall bladder operations, and then to go through a detailed explanation of all the risks of anesthesia once it, already having been established that the procedure is necessary and requested by the patient, doesn't really make much sense, and patients will frequently say, "Look, I need this, to your judgment."

Q. We have been a little bit general up to now. I would like to zero in on the abortion context. Would your answer be the same in that exchange between physician and patient?

A. Yes.

* * *

[115] Q. Now, Doctor, considering those three subsections, what will Section 1870.06(B), as it is presently written—what effect will it have on the informed consent process between the physician and the patient—this whole body of material?

A. To my—in my opinion, it will completely undermine it, because taking Section 3 and 4 and 5 as a unit, it is a very one-sided presentation of all the possible risks, physical and psychological, of an abortion. There are no provisions to inform the woman of the possible benefits or to discuss with her the possible benefits of an abortion.

An abortion is a very painful decision to make, and there are assets and liabilities, and the assets are completely left unconsidered.

Secondly, as I have already indicated, too much detail information has to be given even when this information is really unnecessary when the decision for abortion has been made, and it is quite clear the woman has [116]

a clear understanding that she is not just getting rid of a piece of tissue, that she is getting—that she is asking to be unburdened of a fetus that has the eventual potential for life, and what I am concerned about in this one-sided presentation is that the physician-patient relationship will be undermined, that the patient will consider the physician an enemy who is intent on getting her to keep the baby, that she is again, you know, put—placed under duress and, finally, I think it places a tremendous burden on the physician, because many of them will feel under obligation to reveal certain things in a certain way that they feel is neither accurate nor helpful to the patient.

If the physician then takes the way out and says, "Look, by statute, I am compelled to inform you of X, Y and Z—"

Q. I would like to ask—that is the question I would like to get to.

To come back to that, can a doctor who is compelled to obey the mandate of 1870.06(B) palliate the effects you have described by giving additional information, by saying, "I am required by law to do this," and then give other information?

Will that result in problems?

A. No, because the damage is already done, and as I [117] see the informed consent process, that as one first determines what the woman wants and why she wants it, what situation she finds herself in, and after one has that information, then one has to decide not in a general way, because in a general way, one ought to inform every patient of all risks and benefits, but how specific one has to be about particular risks.

Q. Doctor, what impact will Section 1870.06(B) have on the physician in the practice of his profession?

A. I think it will make it very difficult for him to carry out a meaningful informed consent dialogue because it is, as I said, much too detailed on the one hand, and as I also indicated, not detailed enough in terms of exploring with the woman the other side of the picture and also exploring it in an entirely different way. It is not necessary to have to say all the things that the statute requires, but to use his judgment as to the detail in which he has to proceed in order to make sure that the woman understands everything and also what concerns me, is that either physicians, since they are under the threat of criminal sanctions, will feel obligated to say things that otherwise, in their professional judgment, they might not say and also, that they might begin to say to patients, "Look here, this is a requirement of law, and I have to inform you about all these things."

[118] What I am concerned about then is that patients will become confused and not know when is he talking as a professional in his own right and when is he talking in response to what the statute has imposed upon him.

Q. Changing topics slightly, what is therapeutic privilege?

A. Therapeutic privilege is a legal concept which also has been talked about more since the *Natanson v. Kline* opinion in 1960, and if a patient makes the allegation that he or she has not been sufficiently informed about a procedure, an informed consent has not been obtained, the doctor in defense can assert that it was not in the patient's therapeutic interest to be informed about X, Y or Z.

Q. What purpose, if any, does it serve the physician in the context of informed consent?

* * *

The Witness: It gives the physician professional latitude to at times not follow the mandate of the *Natanson* and *Canterbury* reasoning to fully inform, because [119] the patient's psychological and also physical condition may be adversely affected by this information.

By Mr. Landsman:

Q. Doctor, is there any need for therapeutic privilege in the abortion informed consent?

A. I think there is.

Q Look again at 1870.06(B), sir. Under its strictures, would a physician be able to exercise therapeutic privilege?

* * *

The Witness: Yes, in a number of ways. For example, in cases of incest and pregnancy, rape and pregnancy, or in situations where a youngster who has gotten pregnant being somewhat ambivalent about it has decided to follow the wishes of the parents to have an abortion.

Under these kinds of circumstances, to really go through a detailed explanation of [120] what the fetus might look like at the time of removal, I think, would be extremely traumatic to the persons involved.

By Mr. Landsman:

Q. Doctor, do you find any therapeutic privilege available in 1870.06(B)?

A. I do not.

Q. What effect will the absence of therapeutic privilege have here?

* * *

The Witness: I think it unnecessarily will traumatize a certain portion of women, though one cannot be sure

who will and who will not be traumatized, but there is no reason to even take that chance.

Why take it, then?

* * *

[121] Q. Are there statutes or ordinances, to your knowledge, sir, which utilize criminal sanctions to enforce rules involving the therapeutic interaction between the patient and the physician? Not just informed consent, but the relation between physician and patient more expansively.

A. The only statute to that effect that I know deals with such issues as the reporting of gunshot wounds.

* * *

STIPULATION OF COUNSEL

VOLUME IV

[140] * * *

Mr. Hawley: At this time, Your Honor, we would like to put a brief stipulation on the record that the City and I believe counsel for Intervenors had joined in and that goes to the fact that there are five hospitals in the City of Akron.

Those five are Akron City Hospital, Akron General Medical Center, St. Thomas Hospital, Akron Children's Hospital, and the Edwin Shaw Hospital and that there have been no abortions performed within the last year at Akron Children's Hospital, St. Thomas Hospital, or at Edwin Shaw Hospital.

[141] ***Mr. Bickett:*** Your Honor, we would enter into that stipulation at this time.

Mr. Umbaugh: That is correct, Your Honor.

The Court: All right. The Court shall receive the stipulation.

* * *

TRANSCRIPT EXCERPTS OF DR. CHRISTOPHER TIETZE

VOLUME IV

[*Direct Examination by Mr. Landsman:*]

[143] * * *

Q. Now, what has your work, especially in the past 10 to 15 years, involved, sir? What have you been involved in?

A. Since I have come to New York, NCMH and later the Population Council, I have been concerned with the evaluation of methods of fertility regulations.

In the early years, we were primarily concerned with the evaluation of the effectiveness, acceptability and safety of methods of contraceptive methods, especially of intrauterine devices, and I was involved in a major study of intrauterine devices, which included about 45,000 patients who we followed over protracted periods of time up to six years.

Over the last 10 years or since—really since 1970, I have been primarily concerned with the evaluation of the demographic and public health aspects of induced [144] abortion on a worldwide basis.

Q. Doctor, have you done any consulting work in the same field?

A. I have done a variety of consulting work. My major involvement has been with the World Health Organization where I have participated in the two scientific groups on abortions that they have had, the first one, I believe, in 1969 and the second one in 1977.

I also serve as a Chairman of the Steering Committee of the Task Force on sequelae and complications of induced abortion which has sponsored a number of studies in a number of countries.

Then, for some years, I was a member of the Advisory Committee on Obstetrics and Gynecology to the Food and Drug Administration. At that time, they were and still are concerned with evaluation of contraceptives and I have drafted some of their reports.

Q. Doctor, have you had publications in this same area as well?

A. In the course of my life, beginning in 1931, I have published well over 200 publications in general—in total, mainly in the area of human fertility and its regulation, including more than 60 articles on abortion published in scientific journals, both here and abroad.

Q. Has your work been cited to by the United States [145] Supreme Court in the case of *Roe v. Wade*?

A. Yes, it has.

* * *

[150] Q. Doctor, I would like to turn your attention now to a separate question. Across the United States in percentage of total abortions performed, what is the demand for second trimester abortions?

A. At the present time, or rather 1976, which is the last year for which we have data, we had about just slightly less than 10 percent second trimester abortions down from about 20 percent five years earlier.

Q. If you know, from the information that you have analyzed, who are the women—what category, types of women who seek second trimester abortions?

A. Well, firstly, very young women. Secondly, poor women. Very often, women of minority groups, and because of the association of both poverty and minority status with high birth rate, you also find a somewhat higher proportion of late abortions among the abortions to women of the child-bearing period and that is true for all countries.

[151] Q. If you have analyzed this problem, why is it that these groups of women seek second trimester abortions later than other groups?

A. Well, as far as the very young are concerned, they sometimes are not yet regularly menstruating. They don't know the symptoms of pregnancy. Once they suspect they are pregnant, they may hope it will go away; it may not be true. They practice what psychologists call denial. They are afraid to talk to their elders. In some cases, there may be requirements for parental consent. They may not have the money to pay for their abortion and so forth.

As far as the poor are concerned, they are not able to, as better off people, to manipulate the medical care system, and they get—it takes them longer to go to the right place, to the right person and to get service.

* * *

[157] Q. Doctor, are you familiar with statistics concerning abortion mortality rates in England, sir?

A. Yes, sir.

Q. How do those statistics compare with those of the United States, sir?

A. In overall, their mortality has been higher in England, although it is coming down now, and for the last few years, the mortality for curettage procedures in the first trimester is only slightly higher than the United States.

Q. Has any analysis been made of why the rate of mortality is higher in the United Kingdom that the United States?

A. Well, this has been studied a great deal both by our colleagues and the United Kingdom, and on this side

of the Atlantic, there are two major reasons involved there.

One is--three, rather.

One is that in general, abortions are performed later in the United Kingdom than in the United States, later in pregnancy.

Second, that at least in the early years, they used hysterotomy, which is a major surgical procedure, in a substantial proportion of cases which has declined, but [158] it is still much higher than in the United States, and thirdly, they combine--this did combine in an appreciable percentage of cases the abortion operation with a sterilizing procedure. That, too, has become less frequent, but it was certainly an important factor in the early years.

Q. Was there any other cause for delay built into the English approach to providing abortion?

A. Any other than what?

Q. Any cause for delay not present in the United States?

A. Well, very much so. The English system is quite cumbersome. The woman first has to go to her general practitioner with whom she is registered under the National Health Survey, and then he has to refer her to a gynecologist to do the operation, and if either the practitioner or the gynecologist feels that she doesn't meet the conditions of the Act under which abortion is permissible, she may have to go to another one, and actually, she needs two signatures, a concurrent opinion of two doctors before she can have the abortion, and that causes delay of several weeks on the average.

Q. Doctor, does that delay increase mortality rates?

A. In the light of what I said before, I would say yes, about 50 percent for each week that elapses.

* * *

[*Redirect Examination by Mr. Landsman:*]

[179] Q. I just have one question, Doctor. On cross-examination you mentioned that there was a study conducted concerning comparison between the safety of clinical procedures of abortion and hospital procedures of abortion.

[180] [Q.] Could you just tell the Court what that study demonstrates?

A. This was a very interesting study. It was undertaken because some people claimed that the mortality associated with outpatient procedures, particularly procedures in clinics, was much higher than mortality after abortion in hospital settings.

So, Dr. Grimes, G-r-i-m-e-s, David, and his associates tested this on the basis of '74-75 data. They took, as a denominator, all abortions in clinics and all abortions virtually all of which are first trimester abortions and all first trimester abortions in hospitals, and they found that the mortality of the hospital abortions was about two per 100,000 and of the clinic abortions was about one per 100,000.

Then they eliminated from the denominator and numerator two classes of women: one of women who had a prior medical complication which could increase the risk of the procedure and, second, all cases where the sterilizing procedure was carried out at the same time and after that—and such cases occurred only in the hospital material.

After that was done, the risk to life was exactly the same, one per 100,000 in both series.

* * *

TRANSCRIPT EXCERPTS OF RAY KAPPER

VOLUME IV

[*Direct Examination by Mr. Hawley:*]

[183] * * *

Q. Are you a member of the Akron City Council?

A. Yes.

Q. And are you a particular officer of that Council?

A. Yes.

Q. Which office do you hold, sir?

A. President.

Q. How long have you been a member of the Council?

A. Approximately 11 years.

Q. How long have you been Council President?

A. Two—two and a half years.

Q. Mr. Kapper, were you the sponsor of the abortion ordinance that was introduced in Council in October of [184] 1977?

* * *

The Witness: One of the sponsors.

By Mr. Hawley:

Q. Were you the first sponsor of the ordinance?

A. Well, I asked the Law Department to draft it.

Q. Well, my question was: Were you identified as a sponsor prior to any of the other sponsors of the ordinance?

A. Yes.

Q. Were you also a sponsor of the final version of the ordinance passed in February of 1978?

A. One of the five at that time.

* * *

[187] Q. I would like to know if you talked to anybody, for example, from the Summit County Medical Society regarding their efforts to look into the activities of these clinics prior to your vote on the ordinance?

A. I believe—

The Court: Prior to the time he voted on the ordinance?

Mr. Hawley: Yes.

The Court: Okay.

The Witness: Prior to the time I voted on this final passage?

By Mr. Hawley:

Q. Yes.

A. Yes. Not of introducing it, but passing it, yes.

Q. No conversation prior to introducing it?

* * *

The Witness: Certainly I had conversation with the Health Department.

By Mr. Hawley:

Q. And with officials of the Summit County Medical Society?

[188] A. No.

Q. Prior to the passage of the ordinance, had you visited any of the three clinics in Akron?

A. No.

* * *

[191] Q. Were you familiar prior to the introduction

of the ordinance with what kinds of procedures were available to perform second trimester abortions?

* * *

The Witness: No. The answer would be no.

* * *

[193] Q. Prior to your vote in favor of the ordinance, had you seen copies of any of the informed consent documents which the clinics, the three Akron clinics, provide to their patients?

A. No, I hadn't seen them. I think I indicated earlier I had never been in one of the clinics, only had talked to employees that worked in those clinics.

* * *

[196] Q. To your knowledge, Mr. Kapper, are there any public hospitals or any hospitals owned or operated by the City of Akron?

A. Not presently.

[197] Q. Are there any surgical health facilities of any type owned or operated by the City of Akron?

A. Not presently.

Q. Do you know of any plans for any?

A. Well, not presently.

* * *

[199] Q. My question was: Does it happen and how often does it happen that the City of Akron—that ordinances have been passed subsequent to advice from the Law Department that they are unconstitutional?

* * *

The Witness: Many times.

By Mr. Hawley:

Q. In particular, what instances?

* * *

The Witness: Not offhand, Your Honor. I will be glad to go back, but there have—one I think of was on a—the Law Director, Mr. Baird at that time—there was legislation introduced on vacant buildings [200] as well as vacant gas stations and that and we had passed a law that if they weren't put back into some use within 90 days, they were to be torn down. His advice to us was it was unconstitutional, but we proceeded to pass that. It has not been tested in the courts here in Akron, and we have followed through with that law.

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TRANSCRIPT EXCERPTS OF DR. FREDERICK ROBBINS

VOLUME V

[4] * * *

[*Direct Examination*] *By Ms. Leitzer:*

Q. Please state your name and address for the record.

A. Frederick C. Robbins, 2467 Guilford Road, Cleveland Heights, Ohio.

Q. What is your current position, Dr. Robbins?

A. Dean of Case Western Reserve University School of Medicine. I also hold the rank of Professor of Pediatrics and of Community Health.

* * *

[7] Q. Have you received any awards or honors?

A. I have received some, the most notable of which is the Nobel Prize for Physiology in Medicine in 1954.

* * *

[11] Q. Now could you please turn your attention to the definition section of the Statute 1870.01?

I am going to be referring to Section C in the definition of unborn child, a term which is used throughout the Statute.

Is the term "unborn child" generally accepted in medical terminology?

A. It is not generaly used.

Q. Now I am going to 1870.06, informed consent, in the Ordinance.

The first clause of Subsection (B)(3) states:

"That the unborn child is a human life from the moment of conception . . . ."

Is that a medically accurate statement?

A. That is not a term that scientists or medical people would be able to define.

That does not have any biological meaning as such. It is, in my opinion, it is a matter of religion or moral judgment, not a matter of scientific judgment.

Q. Is there any scientific or medical basis for that statement?

A. None.

Q. Doctor, if you were required by law to comply with the provision of 1870.06(B)(3), that is to state to each patient that the unborn child is a human life from the moment of [12] conception; would you comply?

A. Not willingly, no.

Q. Why not?

A. I find that violates my principles, my moral and ethical concerns.

* * *

TRANSCRIPT EXCERPTS OF DR. CARL WILLIAM KECK

VOLUME V

[*Direct Examination by Mr. Hawley:*]

[40] * * *

Q. Dr. Keck, please state your full name for the record.

A. My name is Dr. Carl William Keck.

Q. How are you presently employed, sir?

A. I am employed by the City of Akron as the Director of Health.

Q. How long have you been the Director of Health in Akron?

A. Approximately two and a half years, since beginning in 1976.

Q. You are a Defendant in this lawsuit?

A. Yes, indeed.

* * *

[*Cross-Examination by Mr. Destro:*]

[56] Q. To your knowledge, are there any clinics run at the Morley Health Center wherein a minor between the ages of eleven and eighteen would come without a parent?

A. Yes. The prenatal clinic is one; venereal disease control clinic is another.

Q. Are there any others besides that, to your knowledge?

A. I am really not sure. I cannot tell you for sure.

Q. Does the prenatal clinic treat minors under the age of eighteen without parental consent?

A. So far as I know, we do not have a signed parental consent form that deals with that age group, correct.

Q. Do you treat minors at the prenatal clinic without notifying parents?

[57] A. I do not believe we do. Obviously if—I think in most cases the people are pregnant, the family knows it. Particularly when they are getting prenatal care.

I am not aware of any requirement for parental consent for us to deal with that pregnancy.

* * *

TRANSCRIPT EXCERPTS OF DR. THOMAS KERENYI

VOLUME V

[*Direct Examination by Mr. Bickett:*]

[69] * * *

Q. What is your present position and what are your present responsibilities?

A. Chief of Obstetrics in the Department of Obstetrics and Gynecology at Mt. Sinai and also in charge of the abortion unit.

Q. Do you have any academic position?

A. Academic, Professor of Obstetrics and Gynecology.

Q. What is your experience in obstetrics and gynecology?

A. Seventeen years, all in obstetrics and gynecology. The past five years have been in perinatology.

* * *

[*Direct Examination by Mr. Landsman:*]

[74] Q. Have you done any research on why women delay in getting abortion?

A. We did. We interviewed some four hundred late aborters, all that came for second trimester abortions. We were trying to find out what makes them delay.

Q. What were your conclusions in that?

A. Somewhat disappointing in the sense we never found one clear answer. Our primary conclusion was that this is one of human nature failing, primarily procrastination.

When we come to a difficult decision, they freeze into inaction.

Q. Who are the women that face these problems?

A. We found mostly the very young, young teenagers; the very [75] poor, and the uneducated. They were the very women who are least capable of coping with the pregnancy at any stage.

Q. What is the medical danger in delay, sir?

A. It has been established that the later you do an abortion, the greater complication rate you are likely to encounter.

Q. Would that apply in these kinds of—

A. That applies at any stage. The later you do it, the more likely that complications will happen.

This carries through all of pregnancy. The later the delivery, the likelier the complications as well.

Q. Is it medically necessary that all second trimester abortions be performed in a hospital?

A. Not at all.

Q. At what point is a hospital presently advisable, given the techniques that we have available?

A. In my opinion that comes in about eighteen weeks.

Q. Why is that, sir?

A. Because I think at that point, the potential complication by the nature of it would best be handled in an institution which has an operating room available at all times; a more sophisticated blood bank than you could manage outside of an institution.

Q. Is there any greater risk to maternal health with respect to second trimester, if they were performed in clinics rather than hospitals?

[76] A. No.

Q. What are the costs of doing second trimester abortions in a hospital rather than clinics?

A. Once you enter a hospital, the cost would jump inevitably.

* * *

[*Cross-Examination by Mr. Dandrea:*]

[91] Q. Given the possibility of who might do counseling, a layman or woman or a physician; would it be your testimony that in all instances the better practice is, it should be done by a physician?

A. That is what we used to think and we found out that patients—or woman counselors without necessarily medical degrees usually end up doing a much better job than we do.

Q. With respect also to medical areas of competence?

A. If they get to an area of questionable medical competence, they can certainly stop there and call us in.

[92] Most patients do not want this, and they feel imposed upon if we jam it down their throats.

* * *

[*Cross-Examination by Mr. Umbaugh:*]

[102] Q. * * * You indicated on direct examination, I believe—and correct me if I am wrong—that in your judgment, 18 weeks was the approximate cutoff for the need for a hospital abortion. That is, after 18 weeks it would be desirable to be done in a hospital. Prior to that, it was not necessary.

Would that also hold true for minors?

A. I do not see the difference. A pregnant woman is a pregnant woman.

Q. If a minor had a complication at 16, 17 weeks; is it not true that hospitals are more equipped physically to handle those complications than the typical clinic?

A. There is nothing magical about the hospital.

Q. My question is: Which would be more capable equipmentwise to deal with the complication, sir?

A. Depending upon the complication, in a hospital you may [103] have a difficult time getting into the operating room because two brain surgical procedures are being scheduled. If you are standing in line with a perforation, you may wait several hours.

If you adequately designed facilities, you may get into the operating room quicker and handle it and nip it in the bud.

If you stand in the operating room corridor for 25 operating—

Q. Your answer concerning a clinic includes a clinic with an operating room?

A. For complications, depending upon the nature of it, an operating room—it happens to be an operating room in a hospital. It may be called a treatment room in an abortion clinic, freestanding.

My point is, depending upon the nature of the complication, you have to be properly equipped. In my judgment—and probably if you ask ten physicians you will get ten different answers—in my judgment, about 18 weeks is where you begin to run into the type of complications. It is hard to care for them outside of the hospital.

* * *

TRANSCRIPT EXCERPTS OF DR. ROBERT BLISS

VOLUME V

[*Direct Examination by Mr. Hawley:*]

[108] * * *

Q. * * * Are you paid for the abortion services which you perform at the Akron Women's Clinic?

A. Yes, I am.

Q. How are you paid?

A. I am paid per procedure and my expenses are paid to come to Akron and to get back.

* * *

[114] Q. If I could call your attention, Dr. Bliss, to Section 1870.07, the next section, entitled "Waiting."; if you were required, Dr. Bliss, to travel to Akron a day in advance of the day when you were scheduled to do procedures in order to give the information required in Section 1870.06, what would you do?

A. Well again, I would comply with the law, if the law required me to do so. However, it would be a great inconvenience to me.

Certainly this would narrow down my chances for being able to satisfy the requirements of the Akron Clinic since there would be fewer days that I would be able to help them out.

There would also be an additional cost to not only travel to Akron, but the cost of my time in giving an extra day to see the same number of patients.

Q. You would charge the Clinic more?

A. I would have to charge the Clinic more.

* * *

TRANSCRIPT EXCERPTS OF FERN CROSSMAN

VOLUME V

[*Direct Examination by Ms. Roberts:*]

[147] * * *

Q. Where are you employed, Ms. Crossman?

A. Summit County Welfare.

Q. In what capacity do you work?

A. I am Administrative Assistant in the Medical Department.

Q. Could you briefly describe your duties and responsibilities as an Administrative Assistant?

A. My field is health. I serve as liaison between providers, providing health information, counseling when necessary, hoping that they are able to talk about their problems.

* * *

[151] Q. Ms. Crossman, now the counseling, the pregnancy counseling you provide to clients; what does this include?

A. Okay. When she comes to me, she, at this point, feels she needs to talk with somebody.

So the first thing we have to establish is that she, indeed, is pregnant. Once that has been established, then we have to talk about the alternatives that are available to her.

There are a number. The fact that we have an agency where we work, where the need for dependent children means, of course, she could continue with the pregnancy and get help through ADC.

Another one would be, she could carry it and put it up for adoption, or if she indicated that termination of

the pregnancy is what she wanted, we would discuss that too.

All of those alternatives must be explored and the opportunity to talk about it and the opportunity to talk about the family as a whole. If she has not been able to talk to anyone in her family, a young person coming to me, I explain she should share some of that with her family.

In a subsequent counseling period, very often the mother will come in and she will have had a chance to talk with her mother.

[152] Then we are able to achieve two goals. One is that she is able to deal with the pregnancy and the other, she is able to reconcile herself with her family.

So then, from there on, we go whichever way she wants to go.

Q. But in situations where the client feels that she cannot or is not willing to share that information with her parents, then you do not reveal that information to her parents yourself?

A. Oh, no. Sometimes you will have a mother who suspects that her child is pregnant. She may call you and ask you and all you can do in a situation like that is tell her that she will have to talk to her daughter about it.

Because we cannot give out any information like that. We would be in violation.

Q. Ms. Crossman, you mentioned as one of the alternatives that is discussed with a client under these circumstances the option of termination of the pregnancy.

A. Yes.

Q. Would this be discussed also with young women under the age of eighteen?

A. Oh, yes. It is kind of interesting because of the fact we are an agency dealing with unwed mothers.

If you have an unwed mother who has one or two children, she is well aware of the stresses and strains. She knows how hard it is economically to deal with it.

* * *

[155] Q. Ms. Crossman, do you, in your referrals to facilities for termination of abortions, do you make referrals to the Akron clinics and the Akron Center for Reproductive Health, Women's Clinic, or Women's Care?

A. All three.

Q. Are you familiar with these clinics?

A. Yes, I have visited each one.

Q. Are you familiar with their staff, their procedures?

A. Yes.

* * *

[*Cross-Examination by Mr. Destro:*]

[169] Q. How many have had that problem, such as an abusive parent or one who impregnated them by incest?

A. Those are usually referred to us by protective services. We might refer them to Children's Services Board as well.

At that point, I would not continue.

Q. How many have you had, that is basically my question. How many have you seen? How many clients have you seen with those problems who were minors?

A. This month?

Q. Fine.

A. I had one this month.

Q. What was her problem?

A. Do I have to answer that?

The Court: You are not talking about any person. You are talking in generalities.

Do not disclose any names.

The Witness: Well, this was a girl of—

The Court: General categories. Was it incest, rape?

The Witness: It was incest.

* * *

TRANSCRIPT EXCERPTS OF KATHLEEN GOTSHALL

VOLUME VI

[*Direct Examination by Mr. Bickett:*]

[19] * * *

Q. Do you have any policy concerning a refund of any of this amount, should the abortion procedure not be completed at your clinic?

A. Yes, we do.

* * *

Q. Ma'am, is the doctor paid at your clinic per procedure, per hour, or per week?

A. Per procedure.

[20] Q. If the doctor decides not to proceed with an abortion, for whatever reason, emotional, medical, or she is too far along gestationally, whatever it is, does he receive the fee as if he had performed the abortion procedure?

A. No, he does not.

Q. Does he receive any fee at all?

A. No, he does not.

Q. Ma'am, in the complaint in this action, there were allegations made that should this Ordinance go into effect, that your clinic would suffer economic loss.

Would you please describe to the Court, if you can, or if you know, what the basis for those allegations are?

A. I know for a fact that most of the social service agencies that refer patients to us, would no longer refer those patients to us. I think we have had testimony to that effect.

A second consideration is, if the Ordinance did pass, it would be to the detriment of the clinic and it would be a fact that we would have to pay for the physician's services, for a physician to come in and do counseling and witness the consent form 24 hours ahead of time. Those are the two major repercussions that I can see.

Q. That would be summed up as additional physician time and possible patient loss?

A. Correct.

[21] Q. Are there any other economic harms which you may suffer other than those two categories?

A. The physician's time, which would also include staff time, additional staff time.

Q. So there would be three then; possible loss of patients, additional physician time, and additional staff time?

A. That I can foresee right now, yes.

* * *

TRANSCRIPT EXCERPTS OF PATRICIA K. BLACK

VOLUME VI

[*Direct Examination by Mr. Destro:*]

[53] * * *

Q. If Donna were to become pregnant and were to seek an abortion, would you wish to be notified?

A. Yes, I would.

Q. Would you state your reasons for desiring to be so notified for the Court?

A. Because I feel that Donna would lack maturity to make a decision on her own. She couldn't possibly, I don't feel, be capable of considering all of the side effects of the [54] situation.

I know that it would probably hinder her physically, mentally, and spiritually, and she couldn't possibly consider all the sides on her own.

* * *

[*Cross-Examination by Ms. Leitzer:*]

[55] Q. If Donna informed you that she was pregnant, how would you consult her? What would you say to her if she came home one day and you observed that she was upset and you found out that she was pregnant; what would you say to [56] her?

A. I would try to comfort her.

Q. What would you say to her about her options; would you discuss those options with her?

A. I personally wouldn't consider an abortion.

Q. Under no circumstances?

A. No.

* * *

TRANSCRIPT EXCERPTS OF NORMA GOLDBERGER

VOLUME VI

[*Direct Examination by Mr. Bickett:*]

[96] * * *

Q. Ma'am, are your doctors paid by the Clinic?

A. Yes, sir.

* * *

[97] Q. If a doctor at some point refuses to perform an abortion on a patient for medical reasons, emotional reasons, whatever the reasons are, does he receive the fee as if he would have performed the abortion?

A. No, sir.

Q. Does he receive any fee?

A. No, sir.

* * *

[116] Q. Ma'am, in the complaint, there were allegations made that your Clinic would suffer economic loss should this Ordinance go into effect.

Are you aware of whether, of what the basis of those allegations are?

A. Yes, sir.

Q. What is the basis for those allegations, in your opinion?

A. There are several different factors of which I need to mention.

The first major concern is the requirement of two trips to the facility. Now, out of surveying 200 of our patients, we find only 50 are from the Akron area and 150 have traveled as far away as Columbus, West Virginia, Elyria and Lorain.

Now, during the course of gathering information for this, we did ask twenty-five patients who were from out

of town, whether this two trip requirement would affect them in their decision to come to our Clinic. More than half [117] of these patients indicated to us that they would not make the trip twice from their home to Akron, but instead would go to the clinic in Cleveland if the Ordinance were to be passed.

Other patients who lived in the City indicated, because of the extra cost of not having to work a work day, that it might make them choose a clinic in another city where they didn't have to make two trips.

Since we are the clinic that does abortions further along than any other clinic in the area, one of the problems we would foresee would be that the rejected patients in these clinics, the ones in this fourteen week LMP period of time, the ones who are rejected on Friday afternoons, if they would come to us the next day, on Saturday for the counseling, the next time that we could see them would be the following Wednesday or Thursday, depending upon the doctor availability. So, that might make them too far along to have a first trimester abortion.

We talked to Planned Parenthood and the Welfare Department who, as I said before, do refer the bulk of our patients to us, and most of these referral agencies say that they will be reluctant to refer patients to our Clinic, not only because of the two trips that are necessary by the Ordinance, but because of the harassing nature of the fetal description which they feel is very unsympathetic [118] to the patients.

In addition, I have discussed with the doctors the impact this would have on them and the physicians that we have available to us on an emergency basis, specifically, the physician from Cincinnati, said that it will be difficult, if not impossible, for him to make a trip here to do the counseling and not do any procedures on that

day and then come back another day. This will be a waste of his time. He does like to have some time off.

Of course, we have another doctor who just changed his position at one of the hospitals in town and in changing his position with that hospital, he has cut down on the time that he is available at our Clinic. He has indicated that he cannot give us more time. In fact, he has to give us less time because of his new commitment.

We have another doctor that said that he would, if he had to tell patients that this was a human life which began from the moment of conception, that he would quit the facility before complying with that.

Another doctor said that if he had to show up and not do procedures, that he would charge us for that, but he didn't know how much.

* * *

[121] Q. Do you know why the information on the fetus would be considered harassment?

A. Yes, because it is information of a highly emotional nature, information which is designed to dissuade women from their choice. It would be as if I were going to a dentist if I had a cavity in my tooth, and the dentist said, "Let me explain how this cavity happened." What I would want to happen is to have my tooth fixed and not have explained [122] to me the nature of the cavity or how it happened.

* * *

[*Cross-Examination by Mr. Umbaugh:*]

[133] Q. Should a minor child wish a parent to accompany her into counseling, yet the rest of the group or some members of the group oppose that, will the parent participate in the counseling with the minor?

A. You are asking for an exception and I am trying to think of what we do under such exceptional circumstances.

We feel that the group is specifically important for minors and we encourage certainly minors to be there just to see that abortions do happen to women in their 40's as do women in their teens.

Q. My question is: In the circumstances where a minor comes into your Clinic with a parent and wishes to go through the counseling with a parent and yet some member or members of the group would oppose that, would then the minor be separated from her parents or parent, nonetheless?

A. Yes, they would be separated. Then they would be allowed to get together again with a counselor to talk about the topics on anything discussed.

* * *

[137] Q. When it's deemed desirable for that minor to receive counseling or, I am sorry, a tranquilizer, how is that conveyed to the doctor?

A. The doctor has a standing order which indicates that a patient, once she has signed the informal consent, has indicated that she is firm in her decision to have the abortion and does not present any other immediate medical problems or any evidence that she has taken any drugs before coming into the Clinic, may be offered 10 mg. of Librium.

Q. So if the Clinic personnel determine that she meets that criteria, it does not—not where the doctor individually advises it, but you do give that tranquilizer to her and it's just policy?

A. It's by his standing order.

* * *

[139] A. Typically, we enter into a discussion of the decision of the patient towards abortion, and this

certainly includes what she feels is best in her conscience and for her life.

* * *

TRANSCRIPT EXCERPTS OF DR. "C"

VOLUME VII

[*Direct Examination by Mr. Bickett:*]

[5] * * *

Q. And could you describe to the Court the contract or financial arrangements you have with the Akron Women's Clinic?

A. I am paid on a per patient basis.

* * *

[6] Q. When you first come in contact with the patient, what do you do with the patient?

A. Typically I go into the room where the patient is located, then I introduce myself. I ask the patient if she has any questions. We go ahead and do a pelvic exam, to ascertain the size of the cervix.

[7] I again ask her if she has any questions and go ahead and mechanically do the procedure.

Then, you know, if everything went smoothly, just tell her, "Do you still have any questions? If you have any problems, definitely get in contact with us."

Then I like to see her in the recovery room and hopefully at the three week follow-up, we will see her again for birth control and a complete pelvic exam to ascertain we have not had any problems.

Q. Do you engage in counselling of any type with the typical patient?

A. Through the clinic, no.

Q. Is there a distinction between your private patients and the clinic patients?

A. Yes.

* * *

[30] Q. Doctor, once again going through 1870.06B, Sub-divisions 1 through 7, I would like to go through the sections this time, Doctor, but keeping in mind not whether the information is typically given, but whether you consider the information relevant in making an informed decision about whether or not to have an abortion.

A. Okay.

Q. First of all, Doctor, do you think it is relevant to making that informed decision about whether or not to have an abortion, number one?

A. It is relevant if she is pregnant. She is there, it is relevant. If she is not pregnant, we do not do the abortion.

Q. Okay. Could I refer you to Number 2 with that question in mind?

A. The question, again, with regards to Number 2?

Q. Whether or not that information would be relevant to the individual making an informed decision about whether or not to have an abortion.

A. It could be relevant.

[31] Q. Okay.

A. I mean, if I tell her she's 24 weeks, she has to make a decision, doesn't she?

Q. Okay. Doctor, referring you now to Number 3, once again, I will sub-divide this section as two compound statements.

Would it be relevant to make a decision whether or not to have an abortion that is the statement that the unborn child is a human life from the moment of conception?

A. That is a theological, philosophical question, I do not think it is relevant, no. She wouldn't be there—

Q. Okay. The second part, Doctor, is that there has been described in detail the anatomical and physiological characteristics of the particular unborn child at the gestational point of development at which time the abortion is to be performed, including, but not limited to, appearance, mobility, tactile sensitivity, including pain, perception or response, brain and heart function, the presence of internal organs and the presence of external members; would that be relevant to making an informed decision about whether or not to have an abortion?

A. Not in my thinking, no.

Q. Doctor, referring you now to Number 4, again with the same question in mind, would that information be relevant to an individual in making an informed decision about whether or not to have an abortion?

A. Yes.

[32] Q. Referring you to Number 5, Doctor, once again I sub-divide this into sections, as it is a compound statement.

First of all, is the statement, "abortion is a major surgical procedure," one which is relevant for an individual making an informed decision about whether or not to have an abortion?

A. I do not think dilatation and curettage is a major surgical procedure, so, no, that is not relevant.

Q. Doctor, referring you to the next part of that, "Abortions can result in serious complications, including hemorrhage, perforated uterus, infection, menstrual disturbances, sterility and miscarriage"; would that information be relevant to the individual making an informed decision about whether or not to have an abortion?

A. I think it should be also included if she takes that pregnancy her chance of having those grow tenfold.

Q. Would the information included in that statement be relevant?

A. Yes; again, it is covered in the informed consent.

Q. Would the statement "Any existing psychological problems she may have," be relevant to an individual making an informed decision about whether or not to have an abortion?

A. If she would have serious emotional, psychological problems, it might be relevant, but the pregnancy can certainly worsen those conditions.

[33] Q. Doctor, would the statement, "Can result in severe emotional disturbances" be relevant to an individual making an informed decision about whether or not to have an abortion?

A. It could be.

Q. Doctor, would the information that numerous public and private agencies and services are available to provide birth control information be relevant to an individual making an informed decision about whether or not to have an abortion?

A. It could be relevant, but she's already at the clinic and she knows what the clinic is.

Q. Okay. Doctor, referring you now to the Number 7, the last statement in that group, "That numerous public and private agencies and services are available to assist her during pregnancy and after the birth of her child, if she chooses not to have the abortion, whether she wishes to keep her child or place him or her for adoption;" would that information or statement be relevant to an individual making an informed decision about whether or not to have an abortion?

A. Right, if she has chosen not to have the abortion, that is very relevant information.

Q. Would it be relevant in making the decision?

A. Again, if she was already at the clinic she's there for one purpose. She's already gone through all the steps to get to the clinic. She's already made her own decisions as to what to do with that pregnancy.

[34] Q. Are you saying, Doctor, then when an individual comes to the clinic she has made up her mind to have the abortion?

A. Sure; when you go to a bar, you go there to drink.

* * *

[*Cross-Examination by Mr. Umbaugh:*]

[43] Q. Doctor, have you, yourself, within the clinic facilities, ever particularly authorized a minor to receive a tranquillizer of any kind prior to that minor receiving counselling?

A. No.

Q. Have you stated any policies to the clinic personnel concerning the issuance of tranquillizers to minors?

A. It is a general policy of the clnic that those who wish it can have a tranquillizer.

Q. Does that include minors, sir?

A. To the best of my knowledge.

* * *

[46] Q. When you consult with a minor, who has come in to your private office for an abortion, do you also consult with her parents at the same time, at that half hour or 45 minute interval?

A. They're sitting side-by-side.

Q. You do not make an effort to separate them and talk to her alone?

A. No, unless she so desires.

Q. In your private practice, in that 30 to 45 minutes, do you discuss, with the parents and/or the child, the fact that you had testified to earlier, that abortions are a bit more difficult or the medical procedure is a little bit harder?

A. The technical procedure? The technical procedure, yes.

Q. The fact it is more difficult on a minor, do you discuss that in your private practice with the child?

A. Sure, I get into rigidity of the cervix and recommend the Laminaria to them.

Q. What does that mean?

A. Laminaria?

Q. Yes.

A. Laminaria is a Japanese seaweed that is inserted into the cervix five or ten hours before the procedure, and it softens and dilates the cervix.

Q. You also often recommend that to a minor prior to undergoing an abortion in your office?

A. Yes.

[47] Q. Do you make such recommendations to a patient at the clinic?

A. No, there aren't any there—they're already there, I am just the last man.

* * *

TRANSCRIPT EXCERPTS OF DR. FRANCOIS SEGUIN

VOLUME VII

[*Direct Examination by Mr. Destro:*]

[49] * * *

Q. Do you have any children?

A. I have four children.

Q. And what are their age ranges?

A. 15, through 8.

Q. Do you have any children of childbearing age?

A. Yes, I have one daughter who is 14½.

Q. Do you have any other children who will be of childbearing age in the future?

A. Yes, I have another daughter.

Q. Did you seek to become an intervenor in this action, Doctor?

A. Yes, I did.

Q. And what were your reasons for seeking such intervention?

A. My reasons were, basically, as a parent with a child who is in the childbearing age group and there was a possibility, even though we brought her up to the contrary, she may become pregnant [50] outside of marriage, despite our counselling and so on. If such a situation were to arise, I felt it was of utmost importance that I, as a parent, would be knowledgeable of such a fact, so I may properly counsel my own daughter. My own moral belief aside, I do not believe in abortion to begin with, but even that aside, even as a parent, I think for the support of my child, who I do not think at 14, 15 or 16 can make a mature judgment as to what

ought to be done in such a situation, that they need my guidance as a parent.

* * *

[51] Q. In your own practice, Doctor, do you treat minors under the age of 18 without parental notice or consent?

A. No.

Q. Are there reasons for this policy that you have?

A. I think the basic reason for this policy is that, frequently without the parental consent children will not follow through on treatment. They will not always follow your advice. Even the older child who is 15 or 16, who I may see for a specific illness, I may advise they ought to stay home for three days in bed or stay home or so on; my experience is children, particularly school age, high school, they are involved with many things. There are football games, they do not want to miss this, particular situations.

Unless the parent is aware of what you have advised the child, they will do many things to get around so they can do their thing.

Even in the office they often frequently say, "Gee, Doctor, I really have to stay home three days? We have a big football game two days from now." They try to convince me to go against my own principles.

I think it is very important the parent is informed.

Recent example, last Saturday I saw a 21-year-old boy, who [52] has a condition, it was rather important he stay home and stay on bed rest for the next 48 hours. I asked him to return at that time for follow-up. Just on a suspicion, I called the father the next morning and the child had gone to work, so I had to have his father

go down and get him home from work, which was really detrimental to his condition.

* * *

Q. * * * Do you, in your own practice, make any exceptions to this rule for specific kinds of illnesses, say pregnancy or venereal disease, for example?

A. Generally in the case of pregnancy or venereal disease, if it is a child under the age of 18, I will tell the child that I will inform the parent of the situation. If it is a cause of venereal disease I also let them know I have to inform the local health department so that this is followed up.

* * *

Q. With regard to minors under the age of 15, do you also [53] require parental consent for many treatments that you would render to such a child?

A. Yes.

Q. What would your reasons be for requiring a parental consent in that instance?

A. I think the reasons for requiring the—my own feelings requiring parental consent is that, even if the child has come to me on his own for an examination, fine, I examine the child. I can explain to them what their problem is and then I explain to them what I feel ought to be done in terms of treatment.

My reason for involving a parent is frequently the child will not follow through on the treatment. Sometimes they do not exactly have a good understanding of what the problem is. I think it is based a great deal on immaturity. I think also the parent is still responsible for that child and that makes it rather important that they know what the child's condition is, why the child is being treated and what the child is receiving.

There are also some circumstances where the parent would rather know also if the child received such and such medication, for example; and so I think this is not strictly a judgment of the 14, 15-year-old. I think the parent has to be involved with that as well.

* * *

[54] Q. Are you familiar with the general pediatrics standard of care in the Akron area?

A. Yes, being involved in pediatrics here for a number of years; being in a group of five other physicians, being on the staff at Children's Hospital, being involved with the care of newborns at St. Thomas, City, General Medical Center, I am aware of what the standards are in the community. If I were not I could not keep my staff positions at these hospitals if I was not following the standard of care in the community.

Q. Is there a general, accepted rule of practice, to your knowledge, in the Akron area of pediatrics regarding notice and consent for medical treatment?

A. I think it is a general rule. My own part, as most of the pediatricians I deal with on a rather daily basis, which involves most of the pediatricians in this community, as a general rule of thumb, parents are notified of the patient's illness, of the child's treatment and generally before the child's treatment is instituted.

* * *

[77] [*Cross-Examination*] *By Mr. Landsman:*

Q. Doctor, I think you prefaced most of your testimony by saying you are opposed to all abortions; is that correct?

A. Yes, I did say that.

Q. I would take it from that statement you are opposed to all abortions in the case of minors as well as adults?

A. Yes.

Q. Doctor, you are opposed to abortions in cases of incest; is that correct?

A. Yes.

Q. You are opposed to abortions in cases of rape; is that correct?

A. Yes.

* * *

[80] Q. Are you involved in any special training in adolescent medicine, things of that sort, on a regular basis?

A. No, this is part of my training in pediatrics.

* * *

[86] Q. What is the percentage of your practice which is teenage girls?

A. That is a toughie. Five percent.

* * *

[87] Q. Now, Doctor, when you are explaining, for example, the risks of an appendectomy, to, let's say, an adolescent, do you explain all the possible complications that might occur?

A. No, I do not, and that is partly because, obviously, I would not be the one doing the appendectomy. I give them a general idea of what is going on, the possible complications of an infection that would involve them staying in the hospital longer; this type of thing.

It is the surgeon who will go into further explanation, whatever he feels.

Q. You do not give them every possible detail?

A. No.

Q. Now, if you were compelled to give them every possible detail, could that be detrimental to their health?

* * *

The Witness: Okay. I think, again, that depends on circumstances and what type of procedure [88] you are talking about. I think that has, too, at times, become an individual judgment. I do not think you can—

By Mr. Landsman:

Q. But it is individualized and there are times you would not want to give every complication?

A. Right, I think that is true.

* * *

Q. Now, in those cases if you thought that notification or inquiry of a parent would lead to further abuse, would you still notify the child's parent about treatment of the child?

A. I think if it is a situation where I felt informing a parent is going to lead to further abuse, you just do not let it drop there, then I think I would try and involve someone else in the situation.

Usually when we are in this type of situation you contact social service at Children's Hospital, so that there is protection [89] for the child.

Q. But—

A. In essence you are informing the parent then to what is going on, so—

Q. But, indirectly—

A. Once I think you feel that the child's welfare is being cared for, he is not going to get into further problems, then you let the parent know.

Q. So you protect the child first; is that correct?

A. Yes.

* * *

[91] Q. * * * If you got notice, unfortunate, that your daughter was pregnant, she was seeking an abortion, would your counsel to her include the positive aspects of the abortion option?

A. No, probably not directly.

Q. If you got notice that your daughter were pregnant and seeking an abortion, would you consent to that abortion if your consent were required?

A. No, I would not.

Q. If your daughter were to commence a court proceeding to seek judicial review of the abortion, instead of consent, would [92] you contest that proceeding?

A. Yes.

* * *

TRANSCRIPT EXCERPTS OF DR. "B"

VOLUME VII

[*Direct Examination by Mr. Dandrea:*]

[97] * * *

Q. And do you receive fees for the performance of abortions at that clinic?

A. Yes.

Q. And that is on a per patient basis?

A. Yes.

* * *

[98] Q. I am asking you now, Doctor, if you can, to go through with what you would say or do with a woman you have met the first time; now you are about to perform this abortion on her; would you just tell us, use the language just as though she is standing right in front of you, would you do that?

[99] A. Well, usually help her to counsellor, then I go introduce myself to the patient and ask do they have any question. If they have any question in that moment and I answer to them and then the patient sign the paper, after I introduce, after the question and then the check of the vital signs and then some patients they need medicine and I give her—I give the order to them. They don't think they want it we don't give them.

Then go to procedure.

Q. Is that medicine to calm their nerves if they are anxious; is that what you mean?

A. Yes.

Q. Where do you meet this patient; what room in the clinic?

A. The counsel room.

Q. And when you are meeting this patient, would she be with a number of other patients as well?

A. Yes.

Q. And would it be fair to say there would be no separation as to ages? There might be young women with older women and so on?

A. Yes.

Q. At that time are they in a gown or are they in their own clothing?

A. They are in their clothes.

Q. All right. Do you leave the room after asking them if there are any questions?

[100] A. Yes.

Q. They are still there when you leave the room; is that it?

A. Yes.

Q. Typically, do very many people ask questions?

A. Right, few people ask questions.

Q. A few?

A. Right.

Q. All right. In the time that you are in the room with that group of women, do you ever use the word "abortion"?

A. No.

Q. Do you ever use the word "pregnancy"?

A. In the counsellor room?

Q. Yes.

A. No.

Q. So it is just in general terms about, "Do you want to go through with it?" That is about it?

A. No, up on the counsellor room, when they come to the procedure room, at that time I can ask them personally. What I mean personal, I can talk to the patient one-to-one, instead of talking whole group together and I particular ask that particular patient say "Is that your decision?" And make sure that she make up her mind before I go ahead.

Q. After you leave the counselling room, where the women are in a group, do you go to the procedure room?

A. Yes—no, I stay for the vital sign, because they—

[101] Q. You check blood pressure?

A. Registered nurse check it.

Q. All right. And then what happens after the vital signs are checked?

A. Then they go change gown and ready for procedure.

* * *

A. Yeah, after they change their gown, then they sit in a room waiting for procedure.

Q. All right. And once again, in the waiting room they are all in a group?

A. Yes.

Q. All right. Is it in the procedure room that you talk to the women individually?

A. Yes.

Q. How long do you spend with a woman individually, in the procedure room?

A. I think around 15 to 20 minute.

Q. All right. What do you say to the patient in that period [102] of time?

A. As I just mentioned, I make sure that was their decision they want. And also I ask them do they have any major medical problem like diabetes, heart problem, seizure problem, something like that. After everything is okay they say, "Yes, this is what I want to be done," then I do it for them.

Q. Would it be correct then that at this point in the procedure room you assume they have already made the decision for an abortion and you do not see your role as counselling them at that point; is that correct?

A. Right.

Q. And at the conclusion of this 20 minutes then the woman assumes a position on a cot or a bed; is that correct?

A. I'm sorry, I didn't hear you.

Q. After this 20 minutes then, you go into the procedure, do you?

A. No, that 20 minute include the procedure—

Q. How much time do you spend talking to the woman?

A. —full procedure.

Before procedure?

Q. Yes.

A. Five minute, ten minute.

Q. Is that when the bimanual pelvic exam takes place?

A. No, that is after I talk to them, then I do the pelvic exam, then do the procedure.

[103] Q. Well, in this 20 minute period, could you

tell us then how much time is taken in talking and how much time is taken up in the actual procedure?

A. About 50-50, about ten minute and ten minute.

Q. All right. And then someone comes in, assists the woman to another recovery room or waiting room of some kind and patient two comes in; is that correct?

A. Yeah, after I do send patient to recovery room, then get ready for the second one.

Q. In your conversations with the patients, would you say that you understand them when they ask you questions?

A. Yes.

Q. All right. Does it appear to you that the patients understand you when you are talking to them?

A. Yes.

Q. Do they ask you to repeat your remarks—

A. Sometimes.

Q. —or comments?

A. Yes, sometimes.

Q. Have you ever received a comment from the patient that, "I don't understand you, Doctor"?

* * *

[104] ***The Witness:*** They don't understand me, the registered nurse stand by, they explain, but I think that happen very unusual, very seldom.

* * *

[110] Q. Would it be correct to say or not, in your experience have you performed an abortion on a woman under 15 even though her parents were not there, at least one parent was not there?

A. I cannot remember, but most generally the parent was there.

* * *

Q. Do you make any attempt to judge the maturity of the patient?

A. What do you mean "maturity"? Can you explain it to me? I don't understand what do you mean by "maturity"? Do you mean, the patient or the—

Q. I am speaking of the maturity of the patient, yes.

A. No.

* * *

TRANSCRIPT EXCERPTS OF FRANCINE LUCAS

VOLUME VII

[*Direct Examination by Mr. Dandrea:*]

[147] * * *

Q. How many counsellors are there at the clinic?

A. Three.

Q. And are they all part-time employees?

A. Yes, they are.

Q. Have you had any previous counselling work or employment?

A. As a respiratory therapist, I did some counselling.

Q. That was to, perhaps, explain to people what to do, maybe if they are having some problems with their breathing after they have operations or something; is that what that is?

A. Yes.

* * *

[148] Q. Now, in your own time there, how much time a week would you say that you spend in the birth control counselling, maybe in terms of hours?

A. Five hours per week, approximately.

Q. All right. So perhaps 15 to 25 hours then are in the counselling for women who might be undergoing an abortion?

A. Yes, also may include other duties, telephone counselling, as well.

* * *

[149] Q. Now, how much of your time might be involved in just answering the phone or perhaps receiving people, as they walk through the door?

A. Per day?

Q. Yes, let's do it that way.

A. One to two hours, approximately, in some instances.

* * *

[150] Q. And would it be fair to say that perhaps 85 percent of the people who come into your clinic undergo the group counselling and do not receive individual counselling?

A. Approximately, I'd estimate that. That's just a figure off the top of my head.

Q. And would it be fair to say that an individual probably would not receive the individual counselling unless she specifically asked for it?

A. In some circumstances we do speak to a patient individually, other than when she may request it.

Q. What might that circumstance be?

A. Ambivalence, possibly, about her decision, concerning the abortion procedure, or if she is a very young woman, in that circumstance, she may be individually counselled as well.

* * *

[152] Q. Could you tell us, perhaps what you typically convey or what information you might receive from a woman in a group counselling session?

A. Usually I would speak to the woman individually for a few moments, giving her ample time to understand that she may change her mind at any point, at anytime she's at the clinic, before the abortion procedure is begun.

I then take her into the group counselling room. She's given a care sheet of instructions and time to read that over prior to the counselling session itself.

She's then given information about the abortion procedure itself, what she may expect to experience during and after the procedure. I tell her how much time she will be spending in [153] each area of the clinic, the laboratory, the procedure room, the recovery room. I explain which personnel members she will have contact with.

I give her information about what she can expect, possibly to experience for the two weeks following the abortion procedure, the aftercare period of time, as we call it.

I may give her information about follow-up examination, when she should have it following the procedure. She's given birth control information at that time also.

She's explained hazards, possible complications that may occur during the procedure. She's given time to read over the consent form and a package that lists the risks and complications that may be involved; and a signature's required on both of those.

She then is in the group session. The patients are then introduced to the nurse and the doctor and they're given ample time to discuss anything they may choose to discuss with those individuals. Then anything, any questions that may arise can be handled individually, when it is going on, any comments the woman may have. It may vary from one session to another, of course.

Q. Would you say there is one or more questions which are more frequently asked of you than other questions, by these women?

A. Yes.

Q. Can you tell us what that question or questions might be?

[154] A. How much pain may be involved is frequently asked. And how much bleeding they can expect to experience afterwards, probably are the most frequently asked.

Q. A moment ago you generically said, "We explain the procedures;" can you use the words now you would use on the woman and tell her exactly what is going to happen to her?

A. Initially the doctor will perform a pelvic exam. I explain to the patient the gynecological table, especially in a circumstance if she has never previously been examined in this manner. I explain to her the position she'll be lying in on the table, exactly what the doctor will do during the procedure—during the examination, rather.

I then show her the vaginal speculum, the instrument that is inserted, initially. I show her illustrations of pelvic exam and illustrations and pelvic organs, which show these instruments in place.

Then I explain to her how the procedure progresses from that point, step-by-step, the antiseptic that is used to clean out the area, vagina and cervix. I explain to her which instruments are specifically used here, tenaculum, which is attached to the cervix at this point to stabilize it.

The patient is then given a local anesthetic, which is injected into the cervix. The doctor begins to dilate the cervix or open it up after that point. This is achieved with a set of instruments designed for that purpose, dilators.

[155] I explain to her how that progresses, starting with the smallest dilator, gradually, step-by-step, opening the cervix, in small degrees, each time by the dilators gradually increasing in size.

Then I show her a suction cannula, which is the instrument that is inserted directly into the uterus. I explain to her what she may be experiencing here, what sensations may be at this point, indicating to her, all along the procedure, how long the procedure may take also.

Let's see, the doctor then uses an instrument called a curette, after that point, to make certain he has cleaned the contents of the uterus out, removes that.

That completes the procedure; is that sufficient?

* * *

[159] Q. Have you graduated from college?

A. No.

Q. Did you attend college?

A. Yes.

Q. Bowling Green?

A. Yes.

Q. Two years?

* * *

[160] Q. Now, you mentioned earlier, I think, respiratory therapy; coming now to your position at the clinic, can you tell us what training you received at the clinic for your position as counsellor?

A. I was instructed by a nurse, who hired me at the clinic, and a counsellor that was previously or presently, at that time, employed there.

Q. Did this training take place at the same time, that is to say, both of them trained you or instructed you at the same time?

A. No.

Q. All right. How much time did you spend with the nurse and what was done in that time?

A. Oh, I spent approximately four hours discussing with the nurse exactly what I would be doing in a counselling capacity at the clinic. Four hours at various times, not at one interval.

* * *

[161] Q. How much time did you spend with the counsellor in this training?

A. About the same length of time.

Q. Was the training with the counsellor something like on-the-job training; that is, were you standing by while she was counselling other people, prospective patients?

A. Initially the other counsellor just spoke to me privately, individually, referring to pamphlets and books and illustrations. Then I did observe her in a counselling session as well.

Q. Was there anytime that you spent with the doctor at the clinic?

A. Yes.

Q. Specifically, toward counselling information or training by him toward you?

A. Yes.

Q. How much time?

A. I would estimate that to be about an hour.

* * *

[166] Q. Is it anyone's responsibility at the clinic to judge the maturity of a woman under the age of 15, who intends to go through an abortion procedure at your clinic?

A. I don't know.

* * *

[168] Q. * * * Of those women who undergo abortions at your clinic, would it be accurate to say most of them had visited your clinic only once, that day of the procedure, wherein they received a pregnancy test, determined to be pregnant and had the abortion?

A. Yes.

* * *

[169] Q. All right. Calling your attention to number three; routinely is it conveyed to women that the unborn child is a human life from the moment of conception?

A. No.

Q. Is it conveyed to her the anatomical, physiological characteristics of the particular unborn child, that which—

A. No.

Q. Is it conveyed to her other such characteristics as mobility, tactile sensitivity, including pain perception or response, brain or heart function?

A. No.

Q. Do you feel any of those things I mentioned in subsection 3 are relevant?

A. No, I don't.

* * *

[170] Q. With respect to your answer number one, two and three, do they still stand then with respect to my question of relevancy?

A. Yes, they do.

Q. Told her number four, capable of surviving outside the womb if more than 22 weeks elapsed from the time of conception?

A. No.

Q. Do you feel that is relevant?

A. Our clinic doesn't see patients that far along in their pregnancy, so I don't feel it is relevant.

* * *

Q. Number five, is it typically conveyed to her that abortion is a major surgical procedure? Well, do you convey it?

A. No.

Q. Do you think it relevant that that information be conveyed to her?

A. That it is a major procedure? No.

* * *

[171] Q. And do you make mention to her there are numerous public and private agencies to assist her during her pregnancy, even to the point of helping her to full term and even to the point of perhaps providing an adoption?

A. Yes.

Q. Is that told to her?

A. Routinely, no.

* * *

[*Cross-Examination by Mr. Umbaugh:*]

[174] Q. What do you understand your role of counselling to be then with a minor?

A. To inform her of what is involved in the abortion procedure, the possible complications that may occur, how to care for herself, so that she progresses and recovers with no problems.

Q. That is all information giving; is it then a fair statement to say when you counsel a minor you understand your role to be information giving only?

A. Yes.

* * *

Q. * * * My question, again is, does it happen at your clinic that a minor under the age of 18 gets only group counselling?

A. No.

Q. In other words, she always gets individual counselling?

A. No, she may—

Q. Explain it.

A. She may get exclusively individual counselling or she may get group counselling and if she's 15 or under, we also speak to her individually.

* * *

[175] Q. And a 17-year-old may only get group counselling; is that correct?

A. Yes.

Q. Does it happen at your clinic that a 16 or 17-year-old, pregnant girl would receive only group counselling when her parents were not on the premises?

A. Yes.

* * *

Q. Have you ever affirmatively contacted a parent with the permission of the minor?

A. No.

* * *

[180] Q. Do minors get that pre-medication on occasion?

A. Yes.

Q. Who gives it to them?

A. The nurse gives it to them.

Q. Do you ever administer that?

A. No.

* * *

Q. Sure. Upon whose authority does the nurse dispense [181] tranquillizers or the pre-medication to minors?

A. The patient's, whose authority, the patient consents herself.

Q. Does the doctor give the nurse permission or instructions to dispense it in any given particular instance?

A. Not to my knowledge; it is a routine procedure.

Q. So, to your knowledge, it would be a decision between the nurse and the minor patient?

A. Yes.

* * *

[184] Q. Miss Lucas, you were asked whether you have, yourself, in [185] your role as counsellor, referred a minor to a physician, other than the physician at WomenCare; I want to ask you whether you have referred a minor patient at WomenCare elsewhere for counselling?

A. Yes, I have.

Q. And under what circumstances have you?

A. Ambivalence about the abortion procedure, definitely if the patient is unsure whether she wants to go through with the procedure.

Q. Then you refer her elsewhere for counselling, before making the decision; is that correct?

A. Yes.

Q. And can you tell us where you would refer her for that counselling; do you make specific referrals, specific suggestions of places to go?

A. No, depending upon where she lives. I try to refer her to somewhere in her area.

Q. Okay. So if she lives in the Akron area is there a particular place you might suggest she should go to get that counselling?

A. Not a particular place, but I can give her a listing and let her select.

Q. Okay. What would that entail, include?

A. Pardon me?

Q. What would that listing include?

[186] A. Shall I name them?

Q. Yes.

A. Portage Path, which is a psychological counselling facility; Western Reserve Rehabilitation, possibly, or various private psychologists or counsellors that she may see.

Q. Miss Lucas, your answer, in response to a question by Mr. Umbaugh, I believe, that you felt that the purpose of your counselling at WomenCare was information giving; is that correct?

A. Yes.

Q. Does that mean that the format of the counselling that you provide to the patients would be in the nature of lecture?

A. In the group session initially it is, but I also provide supportive counselling to the patient.

* * *

[*Cross-Examination by Ms. Roberts:*]

[187] Q. Okay. Let's go back again to the counselling prior to the procedure.

Now, you mentioned that there is initially individual counselling; is that correct?

A. I have a period of time to speak to each patient individually, yes.

Q. Okay. During that period of time, that you speak to each patient individually, are you, during that time, only giving information to her, or are you doing something else?

A. I may be asking her how she feels about the abortion procedure, whether she wants to have an abortion. So I may be questioning her.

Q. And in the counselling with the group, does that process, in addition to providing information, does that include any effort to elicit questions or discussion or responses from the patients who are in the group?

A. Yes.

Q. Is that a large part of that counselling session, a significant part of the session?

A. Definitely is significant. The majority of the time is spent, initially, giving patients information. After that time I engage in a discussion, cross-discussion if you will, with the patient herself.

* * *

TRANSCRIPT EXCERPTS OF DR. MYRE SIM

VOLUME VIII

[*Direct Examination by Mr. Bickett:*]

[24] * * *

Q. Doctor, are you aware of any studies with any conclusion from a psychological viewpoint that abortion is safer than carrying the pregnancy to term?

A. Yes.

Q. What would those studies be, Doctor?

A. Well, I did refer to the flaws in these studies in that they are usually on relatively small samples. In fact, such studies would have declared thalidomide to be a safe drug and actually thalidomide—

* * *

Q. Doctor, these studies, which you are aware of, that had the conclusion that from a psychological viewpoint abortion is [25] safer than childbirth, was there a problem with these studies?

A. Yes.

Q. And what was that problem?

A. The problem was that the numbers that—assuming the condition is not a common condition and, as I said before, assuming it is of the same incident, no more, no less, and the post partum psychosis that they would need to have studies of not less than about 10,000 patients, aside to do a proper control study. I said that had not been done or anything approaching it.

The largest study to date was the one done from Aberdeen where they took 180 on one side and 120 on the other and the surprising thing would be if they found anything in that study and they did not. They said the

results of that study was abortion was no worse than pregnancy. It was not safer, it was no worse. It was a meaningless study in terms of numbers.

Q. Doctor, referring you to what has been marked as a copy of Plaintiffs' Exhibit 44 and at this time, Doctor, I would ask you to turn to Page 3. At the bottom of the page is a Section 1870.05 titled, "Notice and Consent"; do you see that, Doctor?

A. Yes.

Q. Are you familiar with that Section?

A. I have read the Ordinance and I recall reading this Section.

Q. Referring you, specifically, to Sub-division A; are you familiar with that sub-section, Doctor?

[26] A. Yes.

Q. What impact, if any, would that have on an unmarried, pregnant woman under the age of 18 years?

A. I cannot see anything offensive about this.

Not only have I had no information, I know nothing in the literature to support it, so I would say that is quite inoffensive.

Q. Doctor, would there be any specific dangers to a patient whose parents were informed?

A. You are asking me to be a prophet; I find that rather difficult, but I can say that I have not met, in my very lengthy experience, any dangers arising from it, and I know of nothing of that nature that has been reported by other workers. So if there are any, it has been kept a secret.

Q. Doctor, in your experience and based on your studies, how would a minor, that would be under the

sub-division of A there, tend to react to the knowledge that her parents would have to be notified?

A. Well, there is no general rule about it, some are very concerned and do not want the parent to be informed, and others do not object, so you really cannot generalize. But in the instances we have had, where young girls have been in the situation—

* * *

[27] *The Witness:* In the instances which we have had where the young girl was rather concerned about her parents knowing, either myself or my social worker was able, not only to put it that it was going to be helpful to her, but we always found the parents rallied round and were very supportive indeed.

We did not meet a situation where a parent adopted a hostile or threatening or castigating attitude. They realized the daughter was in trouble and as parents it was their job to help her; and as I say we got full cooperation.

Q. Doctor, in the cases dealing with parents and the minors in the problem pregnancy situation, have you had any experience with reactions of the parents to finding out about their daughter's pregnancy?

A. Initially some of them are very shocked and concerned and distressed. Some parents, in fact, want the child to have an abortion and they come with their child for that purpose. Others do not want their child to have an abortion and say, "Can she go through with the pregnancy and we will help her?" You get a variety of reactions, some are anxious for her to have an abortion and others are anxious to go to term.

[28] It is supportive of the role according to their lives. If they feel abortion is the answer, they will

support her on that; but if they feel abortion is not the answer, they will support her in that. Generally it is a supportive, at least in their light, a supportive action.

* * *

Q. Are there any psychological dangers which this Section would create to a pregnant woman under the age of 15 years?

A. I would say to the contrary; I think a girl of 15 needs her parents' support and this is one means of getting it. I think [29] it is helpful.

I would say that not having parental support and to be left to the charity, if you like, of strangers is not the best situation for a girl of 15. I would put my confidence in parental support rather than the professional support.

* * *

Q. Doctor, do you have an opinion, first of all, as to whether or not, in general, a female patient of any age runs a risk of psychological dangers from having explained to her all facts and details about the abortion decision and process?

A. I have not had any such experience, and I know of no such reports. No one has collected even one case where, as far as my reading of the literature, a girl, young girl, who has been told this has suffered a psychiatric illness requiring psychiatric treatment. There is nothing I know of in the literature to support this.

Q. Doctor, referring you, specifically to Sub-division 3, the [30] first statement, "That the unborn child is a human life from the moment of conception;" first of all, Doctor, to your knowledge, is that statement true?

A. That is biologically true.

* * *

Q. Doctor, would, giving that statement that the unborn child is a human life from the moment of conception, create any psychological dangers for patients who would receive it?

A. I cannot see it and I do not know of it. It is true, factual, to say otherwise would be untrue and dishonest.

* * *

[31] A. Usually the pregnant woman or girl is curious about the stage of her pregnancy and she knows that there is a child developing within her. I think if she is going to have surgical intervention she ought to know and probably will want to know the degree of development, because I have had an instance or two instances of women who have had an abortion, but they were incomplete and later, perhaps a week or two later, they found, in the discharge, the remnants of an identifiable human anatomy, like a little bit of a foot or so on, and were horrified to think that their abortion had reached such a stage when it was done.

I know that is much more traumatic, these are cases which have come to my notice and certainly quite traumatic and quite a shock for them to know it had been so advanced, and this was a thing which looked human.

So I will say, in my experience, there is more risk in not telling them, in case they discover later what it really is, than telling them initially.

I think it is standard medical practice in any operation to describe exactly what is going on. In fact, doctors are required, almost by law, to do so.

Q. Okay. Doctor, now, referring you down to Subdivision 5, the statement, "That abortion is a major surgical procedure;" is that statement true?

A. Oh, yes.

* * *

[32] Q. Doctor, referring you to the next part of Sub-division 5, the information that abortion, "Can result in serious complications, including hemorrhage, perforated uterus, infection, menstrual disturbances, sterility and miscarriage and prematurity in subsequent pregnancies;" would the giving of that information create any psychological danger to the patient who receives it?

A. I do not think it would create any psychological dangers in that they will suffer from an illness which will require [33] treatment or may not even be susceptible to treatment. This is very much in the mold of the cautions which are given with most treatments, in fact, not very different to what you may find on a packet of cigarettes, or even a household remedy in a drugstore which you buy over the counter.

* * *

Q. Doctor, referring you now to the next statement in Sub-division B5, the statement, "That abortion may leave essentially unaffected or may worsen any existing psychological problems she may have;" first of all, Doctor, is that true?

A. Yes, "may", yes, but not "will".

Q. Well, on what do you base your opinion that it is true, Doctor?

A. Well, we have the information in our post-abortive psychosis, in fact, that information we gave to the Lane Committee and included in their report and said the caution should be exercised [34] in recommending an abortion to someone with a previous history of mental illness, because there is evidence, quite strong evidence, they are much greater risk to aggravation.

Q. Doctor, referring you to the next statement that that abortion can result in severe emotional disturbances; is that true, Doctor?

A. It can result in severe mental illness, yes.

Q. Can it result in anything short of severe mental illness?

A. Yes, when you have severe mental illness it is really the tip of an iceberg, and underneath you have moderate degrees and mild degrees. In fact, this type of information is coming through from other sources.

* * *

Q. Are you aware of any studies or literature dealing with emotional disturbances after abortion?

A. Well, at the last Canada Psychiatric Association, just almost 12 months ago, there was a paper from Vancouver from a psychiatrist, a Dr. Kent, who reported on 30 patients he had in psychotherapy where the psychiatric problems, and these were only declared, during psychotherapy and not immediately after that abortion, but in psychotherapy their problems were very closely linked with their abortion procedures and their reaction to abortion.

* * *

[35] Q. Doctor, would the giving of information concerning adoption and public and private agencies to assist an individual during pregnancy and after the birth of a child; giving that information in the decision-making process, would that create any dangers for the individual?

A. Well, if a decision-making process is based on options, it [36] must be given and should be given and will not create any danger.

* * *

Q. Doctor, now referring you to the area we have just talked about: Fetal characteristics, is the statement an unborn child a human life from the moment of conception; that statement together with abortion is a major surgical procedure, it can result in complications, can result in severe emotional disturbances; your answers have been that there would be no serious damage from those statements; would that answer change if this information were being given to someone who had already made up their mind to have an abortion?

A. Well, making up one's mind is a very complex situation. For example, we find that unwanted pregnancies very rarely persist after the three months of pregnancy, then it becomes a very much wanted pregnancy and a very much wanted child; that is our experience; I think the experience of most people.

So to say a person has made up their mind, I think, a young girl, particularly, who finds herself pregnant with a social problem involved is not in a position really to make up their [37] mind without knowing what the alternatives are and knowing there is in the society and in the family a lot of benevolence towards her and support which she could have.

So when you say "Make up their mind," I think circumstances are not conducive to a firm decision unless all these other points are put to them.

Q. Doctor, the information, once again, in one through seven, which we have been discussing, would any of that information cause guilt feelings within the individual?

A. Yes, it could.

Q. And could you refer to what information that would be?

A. Well, I think if a person is contemplating an abortion and they know that it is not just a collection of undifferentiated cells with no human connotation whatsoever and they are told it is not that and it is human and they say 12 weeks pregnant and, in fact, the fetus is visibly identifiable as human, this could make them feel very guilty about it; but very rarely.

I will not give you my explanation unless you ask for it.

Q. Is the guilt that would be created from such statements good or bad?

A. I do not see guilt as an evil thing.

* * *

[38] *By Mr. Bickett:*

Q. What impact, Doctor, would those guilt feelings, that are generated, which you have just described, have on the individual who is feeling that guilt?

A. I think this is almost out of the realm of psychiatry. This is almost in the realm of social behavior. I do not think it would be any more severe.

* * *

Q. Yes, Doctor?

A. I say it would be rather similar to someone who feels guilty either having attempted to steal or having stolen. They would be very distressed about it, but we do not necessarily—do not have them coming to us as a psychiatric calamity. It is a learning experience, in fact, and many people would say there is not enough guilt feelings associated with conduct and society.

It is not the policeman, who is watching the individual, that stops crime; it is the person's sense of guilt that what they do is wrong is the biggest deterrent to crime.

Q. Doctor, will the guilt feelings, or can the guilt feelings have any beneficial effect on the individual herself?

* * *

[39] Q. Yes, Doctor?

A. I am sorry, I lost my thought.

I do not think it is in the realm of psychiatry except that, and I think in fairness to the other side, excessive guilt feelings are found in mental illness too. So you can get an excessive reaction to guilt, which is pathological and needs treatment and can be very serious; but all I can say, I have not found that and not heard of it occurring under these circumstances. That it cannot occur, I cannot say.

* * *

[40] Q. Doctor, what is the likely reaction of an individual, such as a minor under the age of 15, what is the reaction of that [41] person and what would they do if they were refused an abortion?

A. There is no evidence of anything catastrophic. For example, suicide is extremely rare. In fact, pregnant girls or mature women have a lower incidence of suicide than women of similar age in the community. In other words, in a way pregnancy is an insurance against suicide, if you like to put it that way; because their incidence is lower.

So, from the extreme reaction of suicide it is less. In terms of mental illness it is also less.

* * *

[42] Q. Would the 24 hour time period, as presented in that Section, create a risk of psychological problems of psychological danger to the patient?

A. I cannot see that at all. I have not met it and do not know of anyone else who has met it.

* * *

[43] Q. Doctor, a wait of 24 or even 72 hours, in obtaining an abortion, would that create a physical danger—

A. No.

Q. —to the patient?

A. I would say, generally, no. One could envision a certain situation where an emergency arises, and even an hour can be a danger; but if there is no medical or surgical problem, no.

* * *

[45] Q. Is the minor more susceptible to problems compared to adults?

A. No, there is no evidence of that. In fact, less probably affected than adults.

* * *

[48] Q. Who should be the one, in your opinion, that explains the aspects as set out in 1870.06?

A. Well, it is general medical practice for the doctor to do that. He knows what he is doing. He knows exactly what the position is. He has the experience. He can answer the questions that may follow.

It is not just giving them this information, you have to be prepared to answer some questions. I do not think anybody, other than the doctor himself, can do that. This is very technical and anybody else would be presumptuous.

* * *

[*Cross-Examination by Mr. Destro:*]

[52] Q. All right. Thank you.

With regard to the psychological maturity of an adolescent, would there be any specific problems, to your knowledge and in your experience, in the reaction of an adolescent to a pregnancy or abortion situation?

A. The thing that surprises one is how relatively unaffected they are sometimes, compared to adults. They seem to take these experiences surprisingly well.

Now, one may argue this, maybe an initial stage and later on they may not, but in one's subsequent study of patients who may have had abortions early on, they do not seem to be traumatized. They are surprisingly unaffected.

* * *

[*Cross-Examination by Mr. Landsman:*]

[54] Q. Doctor, I noticed on your resume that one of the articles you have written concerned the use of oxypertine in combination with imipramine? Is that right?

A. That is quite right.

* * *

Q. * * * With reference to that one, those drugs are psychoactive drugs, are they not, sir?

A. Yes.

Q. The paper that you wrote on that report describes an experiment on psychotic patients, does it not?

A. Yes, depressive patients.

* * *

[55] Q. * * * Now, did you ask them, each of the psychotics in the hospital, to consent to the procedure?

A. Oh, yes.

Q. You did?

A. It is mandatory.

* * *

[56] Q. * * * Who obtained the consent?

A. I did.

Q. Were you connected with the experiment?

A. Yes.

* * *

[57] Q. Was consent obtained for this experimentation from anyone other than these patients in the hospital?

A. No, they are all responsible citizens who are capable of giving valid consent and information which would –

Q. Were guardians or relatives, outside the hospital, even [58] notified of the experimentation?

A. Oh, yes.

Q. They were?

A. Oh, yes.

Q. But their consent was not gathered?

A. No, not necessary, no. Not according to our laws, no.

* * *

Q. Was each patient in this experiment told that the two drugs used could have possible side effects, including convulsion, cardiac arrhythmia, seizures and a long list of other problems?

A. With imipramine that has been defined and these are listed, yes.

Q. Were they all told, each patient told of those risks?

A. Yes.

[59] Q. Each patient was told of those; is that right?

A. They were all listed.

Q. They were listed in writing, sir?

A. Yes.

Q. They were given to a patient?

A. Yes.

* * *

Q. Was each patient told, Doctor, the amount of the drug, the effective dosage of the drug? Doctor, that has not been actually defined.

A. Oxypertine we are not sure how much they should have.

Q. Had the patients been told that?

A. Yes.

Q. Was it true, Doctor, 56 percent of the subjects suffered side effects from the drugs?

A. Yes.

Q. Is it also true, Doctor, their side effects lasted more [60] than one week?

* * *

A. Yes.

* * *

[79] Q. All right. In your experience, as a psychiatrist, as a medical professional, are parents always supportive of their minor children?

A. In the circumstances of a pregnancy, yes.

Q. All the time, every case?

A. In our experience.

Q. That means in the 56 cases you have seen—

A. Or more, because it did not all come from abortion.

Q. But in every one of those cases the parents were supportive?

A. We found that there was sometimes initial reaction and being upset and felt let down, but, as I said in my

testimony, a very short time even when it was negative initially, that was very soon put right.

Q. So in every case the parents were supportive?

A. We were able to enlist the support of the parents.

Q. Now, Doctor, have you ever dealt with any cases of child abuse by parents of their children?

A. Yes.

Q. In those cases were the parents supportive of their children?

A. Frequently they were very fond of their children.

* * *

[80] Q. Now, in cases of child abuse, sir—

A. Yes.

Q. —I asked you, have the parents in those contexts been supportive of their children?

A. Well, if they have beaten the children then, obviously, they are not supportive in all respects.

Q. Have you ever dealt with any cases of incest?

A. Yes.

Q. Now, in those cases have the parents been supportive of their children?

A. No.

* * *

[82] Q. Now, that would be in all cases? There would never be a case then, Doctor, where patients would say, "I don't want to hear more, you are causing anxiety. I don't need to know more, please don't tell me." There were never—

A. I could not say never.

Q. You could not say no?

A. No.

Q. There might be some cases?

A. It is always possible.

Q. In those cases should the physician persevere, should he press forward with his statement?

A. I do not think one can give a general answer to it. He has got to use his clinical judgment and in most instances he should be able to overcome this resistance. It is just possible for [83] some strange reason this person is so unstable—

Q. Now, this is not most cases, Doctor, I am talking all cases. Are there cases where he should not persevere?

A. I have no experience with a case where that is a risk.

Q. That is not my question. If that kind of case arose, should he persevere?

A. To the nth degree, you mean?

Q. Should he carry on with the description of the fetus or all the risks of the procedure, or whatever?

A. Well, if one is faced with such an unusual situation—

* * *

I say if one is faced with such an unusual reaction I would be severely concerned about the stability of the individual and what is causing this extreme reaction and the whole attitude to the abortion procedure. It would widen the scope of my problem, I would have to think I am dealing with a sick girl, who is already sick, who is asking for an abortion. Her sickness in itself may require—

The Court: Well, the answer to [84] the inquiry is, should you continue carrying on instruction and describing the provisions outlined in the Ordinance?

The Witness: No, if I decided she was sick.

The Court: In other words, you are saying there may be a case you should not; is that correct?

The Witness: Oh, yes, there could be instances you should not.

* * *

[88] Q. All right. In giving informed consent information, Doctor, is it important to discuss all the options available to the woman?

A. All reasonable options.

Q. Now, do you see, in this material, 1870.06B, any discussion of the potential advantages of abortion?

A. I do not know the advantages, perhaps you can tell me what is omitted.

* * *

The Witness: I do not know any advantages.

* * *

TRANSCRIPT EXCERPTS OF DR. JOHN C. WILKE

VOLUME IX

[*Cross-Examination by Mr. Landsman:*]

[66] * * *

Q. Doctor, is it your opinion that all women who seek an abortion should be shown the photographs of the fetus and have a description in detail of fetal characteristics, sir?

A. Yes.

Q. What if a patient says that she does not wish to see the photographs?

Would you persevere anyway, sir?

A. I would tell her that she would see them sometime in her life and I believe that it is in her interest that she look at them prior to her having the procedure for they might influence her judgment at this time.

Q. If they request that they not be shown to her, sir, would you persist?

A. I certainly would not.

Q. If she requests that you not go into any description of the fetus, would you still describe the fetus to her?

A. In her best interest I will try to have her accept that information but if she refuses, then as a counselor I will not persist.

Q. Can the doctor's use of words like "baby" or "unborn child" influence or affect a patient trying to decide on whether to have an abortion or not?

[67] A. This is probably true. It swings both ways. If one uses a term that is commonly associated with "baby" or "live child", that might well have an influence.

If you use a term that is commonly accepted as nonhuman, such as "embryo" or "fetus", then that also has an effect.

Q. Doctor, is the following a correct quotation from your book, "Handbook on Abortion" at page 198?

"'Product of conception, fetal tissue, globe of protoplasm, fetal placental unit' and other high sounding phrases are all direct denials of the humanity of the growing child. Make up your mind. If you are convinced that this is a human life call it such. Then consistently speak of he or she, not it, and speak of an unborn, preborn or developing child or baby. It is easier to approve killing of a fetus, much more so than the killing of an unborn baby."

Doctor, is that statement from your book?

A. That is correct, a correct statement.

* * *

TRANSCRIPT EXCERPTS OF DR. RICHARD T. F. SCHMIDT

VOLUME X

[*Direct Examination by Mr. Bickett:*]

[13] * * *

Q. Doctor, are you aware of any policy of the American College of Obstetricians and Gynecologists, or of the hospital in which you practice, concerning surgical procedures on individuals under the age of 18 years?

A. Yes. It is standard practice and habit throughout my medical career to have consent from parents of a minor child for any surgical procedure.

Q. Are there any exceptions to this, Doctor?

A. In a life-threatening emergency, but even then the permission is obtained at the earliest possible time.

* * *

Q. Doctor, based on your studies and reading of literature and your own experience, what is your opinion concerning [14] the capability of an individual under the age of 15 to give an informed consent in that situation?

A. Well, I think it is very limited. In my medical practice I would never attempt to undertake a surgical procedure on a minor child without having explained it to the parents. The younger the minor child, the more this is required.

Obviously if a child is responsible, I would include the child and do. This is pretty standard practice, but not only is an abortion not any different kind of situation, and in many ways I think it requires more attention to be sure of understanding and mature judgment, and this is why I believe that involvement of the parents is perfectly appropriate and necessary.

* * *

[*Cross-Examination by Mr. Landsman:*]

[38] Q. Doctor, you don't perform any abortions, do you?

A. Elective abortions, no.

Q. The hospital for which you work does not perform abortions, does it?

A. That is true.

Q. In fact, the hospital for which you work has a policy prohibiting abortions; is that correct?

A. That is true.

* * *

Q. You are prohibited from performing abortions by a sectarian rule?

A. We are prohibited by a rule. If you characterize it [39] as sectarian, you may do so.

Q. Do you not receive instructions under the guidance and religious direction from the Catholic Health Association?

A. There is such a directive.

Q. And you follow that directive on abortions?

A. The hospital rule follows that directive, correct.

Q. Doctor, do you personally oppose all abortions?

A. I do not oppose anybody doing—well, I do not oppose—everybody doing an abortion under any circumstances. It is not a general opposition. I believe that abortion is inappropriate medically and ethically, and I do not do them, but I just want to make it clear, and I believe my general background indicates that I believe in the pluralistic society—

* * *

[84] Q. Let me ask this again:

If that young woman told you that she did not want to hear any more material of the type contained in (b)(3) before you got into the anatomical description, would you tell her anyway?

A. If I had no assurance that she understood that information to begin with, I would tell her in exactly the same sense that someone who is to undergo any other surgical procedure said, "Look, don't tell me that."

I might limit the amount I told her, but I would still feel obligated to be sure she understood.

If she said to me, "You don't have to tell me, I understand these risks," then that would have fulfilled my obligation.

* * *

[85] Q. Now, that patient tells you that she understands that it is a baby and growing in her, and she doesn't want to hear that anatomical description, and it will cause her pain; would you proceed to do it anyway?

A. No. If she understands, then I have fulfilled my mission in being assured that she has that information.

* * *

TRANSCRIPT EXCERPTS OF DR. JASPER WILLIAMS

VOLUME X

[*Cross-Examination by Mr. Destro:*]

[142] * * *

Q. Do you have an estimate from your experience of how long it would generally take to resolve such a kid's perception of how her parents would act or resolve her situation with the parents after her actions, from your experience?

* * *

[143] A. * * * Some kids at 14 are more mature than their parents, and you have more trouble talking to the parents than the patient, so I can't put on a time limit, but I would say 15 minutes to an hour or an hour and a half, and sometimes it goes two hours.

* * *

TRANSCRIPT EXCERPTS OF DR. MILDRED SHELLY

VOLUME X

[*Direct Examination by Mr. Dandrea:*]

[186] * * *

Q. In your practice or experience could you say typically how long a period of time you might spend counseling one contemplating an abortion?

A. Personally I would prefer to spend at least two to six sessions with the person.

Q. How long a session?

A. At least an hour.

* * *

[187] Q. What area might you cover in the counseling of a woman contemplating abortion?

A. Primarily I would begin by putting out the extreme importance of her as a person to me. I would try to give her some concept of what she tells me of how I see the stress which she is having, and then I would ask her if I were on the right path with her; in other words, have we established a rapport.

Beyond that I would ask her what she might have and how she might see her own survival, as well as that of the child within her.

Q. In your discussions with her, would, even in a general fashion, would her own obstetrician come up in this conversation?

A. That may be the case, yes.

Q. Would you ever suggest that she have counseling with him and discussion, anything with him?

A. Very definitely.

* * *

[192] Q. In the context now of counseling anybody now, whether an adult or minor woman, could you give us what in your opinion is the significance here of informed consent and some of its ramifications?

A. I think in counseling anyone, particularly now, there is a very great need for informed consent, because I think very often we as physicians—and I am speaking for myself, if I may—I think that we are not always perceptive enough to know when the patient herself—I know very often myself in talking to patients have them give me some kind of feedback, so I know we are tuned in on the same channel, as it were, because when people are under stress, there is a tendency to distort what they hear, and if you don't get immediate feedback and reinforcement of the understanding, you may find yourself in difficulty the next time that [193] you talk to the person.

Informed consent too I think is the acknowledgment with whatever intelligence the person has with whom you are talking in trying to explain a procedure to them, and the alternative and the results.

Q. Well then, was there not restrictions tied to abortion in any area on how much ought to be told or communicated? When does, in general terms, when does this informed consent become truly informed?

A. When you get some feedback that they understand the nature of the procedure in their own terms and their own language, and if you can't explain it to them, you better get somebody who can in terms of their language, or if they might be deaf or something, and you have to have understanding from them about why they are there for the procedure and what constitutes the procedure and what might happen.

Q. What might the results be if perhaps a given area of this discussion is omitted, whether advertently or inadvertently?

A. If the natural reality of the issue of abortion is not understood, depending upon the level of the person, it quite often is a shock to them, especially for early adolescence, because abortion very often [194] directs itself to relief of the stress of the mother, and at some point in time, as the youngster grows older, they become aware of the fact that this was indeed another person.

* * *

[195] Q. Could you state, Dr. Shelly, in the role here of counseling or treatment here with, let's say an unmarried minor contemplating an abortion, does the counseling or perhaps the language thereof in any [196] way affect that person's maturity?

A. There is ultimate maturity, and I wouldn't say, but there is maturity as they are going through adolescence, and I think it would affect it for this reason:

They need parents. They need parents to be children, and to survive to adolescence, and they need them, not necessarily for the support they are going to give them, but because they need them at the taking off place into their own adulthood to separate themselves and begin to adopt their own adult roles and find their own sexual identity, and all of these things, positive or negative, these parents represent roles to them.

* * *

PLAINTIFFS' EXHIBIT 10

AKRON CENTER FOR REPRODUCTIVE HEALTH
CONSENT TO ABORTION FORM

I, _____,
age _____, hereby give my consent to, and request and authorize Dr. _____
or whomever he/she may designate, to perform upon me, an ABORTION, and if any unforeseen condition arises in the course of the abortional procedure that in his judgment calls for procedures different from or in addition to those now contemplated, including but not limited to, the administration of anesthesia and the administration of Rhogam. I further consent to and request and authorize said doctor and his assistants to do whatever else he or they deem advisable in the exercise of his or their best medical judgment.

As in any surgical procedure, bleeding and infection are potential complications of abortion procedures. These complications could cause prolonged illness, the need for blood transfusions, and permanent inconvenience and disability. During the course of the operation, it is possible that the wall of the uterus will be perforated or punctured. This could cause pelvic bleeding and infection, and even bleeding and infection in the abdomen. Problems with blood clots in the legs, pelvis, and lungs also rarely occur after abortion procedures. There is also a very remote chance that one or more nerves going to the legs will be injured during the operation.

Some of the complications of this operation can require further major surgery; some could potentially result in sterility or the permanent inability to become pregnant again; and very rarely, some of the compli-

cations can even be fatal. There are other potential complications from the abortion operation in addition to the ones that have been mentioned. However, it is not possible to advise you of every imaginable complication. The complications referred to are very unlikely. The purpose of this consent form is merely to insure that your decision to have an abortion is not made in ignorance of the risks of this kind of operation.

I further consent to the disposal by my attending physician or his assistants of any tissues or parts which may be removed during the course of the abortional procedure.

I acknowledge that no guarantee or assurance has been made to me as to the results that may be obtained as a result of submitting to an abortional procedure.

Date _____

_____

Signature of Patient/Consentor

_____

Witness (Counselor)

PLAINTIFFS' EXHIBIT 17

AKRON CENTER FOR REPRODUCTIVE HEALTH
DEMOGRAPHICS ON PARENTAL KNOWLEDGE
December 1977-July 1978

One or more parents (or legal guardian)—*Aware*

Total		10 wks	10 wks	11 wks	12 wks	(abortion not done) 12 wks
23	17 yrs	6	9	4	4	–
14	16 yrs	5	3	2	2	2
14	15 yrs	5	6	1	1	1
7	14 yrs	2	1	1	1	2
–	13 yrs	–	–	–	–	–

* * *

Seven month *combination* stats.
(Dec. 77 → July 31, 1978)

	Aware	*Unaware*
17	68	116
16	68	49
15	61	13
14	26	3
13	5	–
12	2	–

PLAINTIFFS' EXHIBIT 24

AKRON WOMEN'S CLINIC STATISTICS ON FIRST 650 PATIENTS May 1977

AKRON WOMEN'S CLINIC would like to share with you the results of a study of our first 650 patients. We intend to study the demographic characteristics of our patients on a regular basis and to keep you informed of these results, and of our clinic's news. If you do not wish to be on our mailing list, please inform us. If you know of someone who would like to receive our newspaper or our brochures, do let us know.

* * *

Complication Rate

We intend to be honest about our complication rate. However, we only have reliable statistics on patients who are treated by our physicians. If you are a physician treating one of our patients with a problem related to the abortion procedure please inform us.

To date we have performed about 650 abortions. We are aware of a total of 5 patients who have been admitted to the hospital subsequent to the abortion. Of these, one was admitted for observation only and was released the following day without requiring further treatment, another was reaspirated under local anesthetic and discharged, another said she was admitted for an infection but then had a tubal ligation, and 2 required laparotomies for repair of a cervical and/or uterine perforation.

Hospital admission rate = .8%.

Four of our patients required reaspirations at our clinic. These are performed at no charge to the patients.

Outpatient reaspiration rate = .6%.

One of our patients was diagnosed as having a hydatidiform mole.

* * *

PLAINTIFFS' EXHIBIT 30

AKRON WOMEN'S CLINIC
INFORMATION SHEET REGARDING PREGNANCY

YOU THINK YOU'RE PREGNANT AND YOU'RE WONDERING WHAT TO DO . . .

You've missed your menstrual period (or had one lighter than usual which happens to some women when they're pregnant) and maybe you have some of these feelings:

you're just too tired, breasts are sore, sick to your stomach, hungry like never before, or "it feels just like it did those other times".

Find out if you really are pregnant (once in a while it's something else).

What To Do . . . .

For *$2.00* we have a test that works *32* days from the first day of your last period. For a *free* pregnancy test count *42* days from the first day of your last regular period (your period is now two weeks late), take your first urine sample of the day in a clean jar (refrigerate it and keep it cold) and bring it to us. We will give you the test results the same day.

If the results are negative, have it run again in 1-2 weeks or see your doctor, or both. Do find out what's causing your period not to come!

If the results are positive, you are pregnant. Now is the time to make your decision about pregnancy!

What are your choices?

Carry it full term and mother the child. See your doctor or health center for good medical care.

Carry it full term and plan for its adoption. See your doctor and decide on a referral agency, or ask us for recommendations.

Have the pregnancy terminated at our reliable abortion clinic. Everything is strictly confidential at Akron Women's Clinic. Excellent counseling is available if you want help in making your decision. We believe the *best* decision is the one you want for yourself. There is *no charge* for decision-making counseling.

If you're choosing an abortion, try to make plans as quickly as possible. Early terminations are safer, simpler, and less expensive than later procedures.

Read what an abortion is like. Turn this sheet over.

* * *

PLAINTIFFS' EXHIBIT 32

AKRON WOMEN'S CLINIC
PATIENT INFORMED CONSENT FORM

AKRON WOMEN'S CLINIC
513 West Market Street
Akron, Ohio 44303
(216) 535-6178

INFORMED CONSENT TO TREATMENT ANESTHETIC, AND OTHER MEDICAL SERVICES

Patient Name:

Date:

State Law requires us to obtain your consent to your contemplated surgical procedure. What you are being asked to sign is simply a confirmation that we have discussed your contemplated medical procedure and that we have given you sufficient information upon which to make a decision whether to have the procedure performed of your own free will. We wish to inform you, not to alarm you. If you wish, we can go into more elaborate details of more unlikely problems that are not contained in this form. If you do not, that is also your privilege. Please read the following form carefully and ask any questions that you may have before signing it.

1. I, _____
am _____ years old, and request and consent to the performance upon me of a pregnancy termination procedure, vacuum aspiration, at Akron Women's Clinic, by Dr. _____, or a designated associate physician.

2. I further consent to the taking of cultures and the performance of reasonably indicated tests and procedures in addition to pregnancy termination, whether or not relating to presently known conditions, if my medical attendants find these necessary or advisable in the course of evaluation or treatment, for management of complications or otherwise.

3. I have fully and completely disclosed my medical history, including allergies, blood conditions, prior medications, or drugs taken, and reactions I have had to anesthetics, medicines, or drugs. I consent to my physician's relying on this disclosure as complete.

4. I consent to the administration of such anesthetic as may be deemed necessary or advisable by my physician or associates. Local anesthetics do not always eliminate all pain, and in a small number of cases local anesthetics cause severe reactions or even shock, and no guarantees to the contrary have been made to me.

5. The first day of my last menstrual period was _____, 19___. This period was (check one) ___ normal, ___ heavy, ___ light. The period before it was ___ normal, ___ heavy, ___ light. My periods in the past six months have been ___ regular, ___ irregular, ___ other. If "other", describe: _____

_____

_____.

I understand that information concerning my last period is important to diagnosis and method of treatment, and I consent to treatment based upon my recollection as stated above, or upon findings from examination.

6. I understand that tissue and parts from inside the uterus will be removed during the procedure, and I

consent to their disposal or use by the clinic and/or physician in the manner they deem appropriate.

7. I fully understand that the purpose of the procedure is to terminate this pregnancy, and I affirm this to be my personal choice in light of the alternative of continuing the pregnancy to term. No one has coerced or compelled me to make this decision.

8. I understand that the complications associated with pregnancy termination are generally much less severe than with childbirth. Nonetheless, I realize there are inherent risks of minor and major complications which may occur in this as in all surgical procedures, without the fault of the physician. No guarantees have been made to me. I understand the possibility of perforation of the uterus and internal injuries resulting therefrom. I understand the possibility that not all of the tissue will be removed, that fever may occur, that bleeding may occur during or after the procedure, that infection may occur, that I may react badly to medicines or the anesthetic, that I may have pain, cramps, or even convulsions. I also realize the possibility of blood clots forming. Some of the complications may result in sterility as may repeated abortions. Though extremely rare, I realize that some complications could even lead to death. I further realize that I may need to be hospitalized for treatment of such complications and that operative procedures such as Dilation and Curetage and/or Hysterectomy may be necessitated at that time. I am fully aware that I will incur the cost of such hospitalization or treatment.

9. If I accept birth control I understand I may also have a mild or severe reaction to the contraceptive method.

10. I understand the importance of follow-up care and agree that I will arrange to have a pelvic examination by a qualified physician not sooner than 10 days nor later than 21 days following the pregnancy termination procedure.

11. I understand that any questions I have will be answered by my physician, nurse, and/or counselor, and I will ask such questions before leaving the facility.

12. If I have questions or complications after leaving, I agree to call the physician or clinic at (216) 535-6178 immediately.

13. I further understand that the medical practice of my physician is to be judged according to those standards reasonably acceptable to other physicians practicing in similar facilities in the United States.

14. I agree that the consent given herein shall be binding upon myself, my heirs, executors, administrators, and assigns.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE INFORMED CONSENT, AND THAT I AGREE IN LIGHT OF THAT CONSENT TO THE PREGNANCY TERMINATION I HAVE REQUESTED. I ACKNOWLEDGE THAT ALL INFORMATION REGARDING THE NATURE, PURPOSE AND RISKS OF THE PREGNANCY TERMINATION HAVE BEEN DISCLOSED TO ME AND THAT ALL QUESTIONS ASKED HAVE BEEN ANSWERED IN A SATISFACTORY FASHION.

DATED: _____

_____ _____

Physician Signature of Patient

_____

Witness

I/We the undersigned, being the parent(s) or legal guardian(s) of the above named patient, certify that I/we have read the above consent to abortion and/or pregnancy termination; that I/we fully understand the contents thereof and do hereby give my/our authorization and consent to the performance of the surgical procedure described therein on the above named patient. I/we understand that part of the professional services includes birth control information and counseling, a month's supply of birth control pills, if she desires, plus a prescription for birth control pills at her three (3) week check-up.

Witness: _____

_____ _____

PLAINTIFFS' EXHIBIT 37

WOMENCARE
PATIENT INFORMED CONSENT FORM

WOMENCARE, INC.
759 West Market Street
Akron, Ohio 44303

The nature and purposes of an abortion, and the possibility of complications have been fully explained to me.

The complications include:	*The risks of these complications include:*
Infection	Hospitalization
Hemorrhage	Transfusion
Drug Sensitivity	Additional operation
Perforation of Uterus	Removal of uterus and subsequent loss of childbearing
Incomplete Abortion	Death
Continued Pregnancy	Continuing the pregnancy which may be damaged

I authorize appropriate disposal of tissue removed, including pathological examination. I confirm to the best of my knowledge, that my Last Menstrual Period (_____) is accurate and true.

I understand that it is my responsibility to take my medications as directed, to bring to the attention [the clinic] any unusual symptoms following the abortion.

I certify that I have read and fully understand the purposes of an abortion, the risks involved, and that no promise has been made that I will have no problems as a result of the abortion. The explanations referred to

were made and all blanks or statements requiring insertion or completion were filled in. All my questions have been answered to my satisfaction.

I understand that if I should have a complication, it may become necessary to involve my family.

_____

Signature

_____ Date

_____

Signature of Parent (Legal Guardian)

_____ Phone

_____

Address

_____ Date

_____

Witness

_____ Date

PLAINTIFFS' EXHIBIT 45

CHAPTER 3701-47, "ABORTIONS" OHIO ADMINISTRATIVE CODE

ABORTIONS

Note: Chapter 3701-47 of the Administrative Code was filed pursuant to Chapter 119 of the Revised Code.

* * *

3701-47-01 Definitions

As used in rules 3701-47-01 to 3701-47-07 of the Ohio Sanitary Code;

* * *

(E) "Fetus" means the developing conceptus from fourteen (14) weeks after the first day of the woman's last menstrual period until birth.

* * *

3701-47-07 Counseling

(A) The fact of the availability of both pre-abortion and post-abortion counseling for herself and other persons of her choosing shall be made known by the physician, to each woman who is seeking the abortion of a fetus.

(B) Counseling shall be non-judgmental, regardless of the circumstances of the pregnancy, but shall not be forced upon the woman.

(C) The woman shall be treated in a safe, humane and dignified manner during the counseling period and throughout her stay at the place where the abortion is performed.

* * *

PLAINTIFFS' EXHIBIT 46

AKRON CITY HOSPITAL
ABORTIONS—ELECTIVE AND THERAPEUTIC

A. TOTAL ABORTIONS PERFORMED:

In patient May 1977 thru February 1978 (March & April not available)	14
Out patient May 1977 thru April 1978	58

B. NUMBER PERFORMED IN EACH TRIMESTER:

	1st Trimester	2nd Trimester	3rd Trimester
In patient	8	6	0
Out patient	58	0	0

C. NUMBER CLASSIFIED AS THERAPEUTIC:

In patient (5 of these were for removal of dead fetus)	10
Out patient	4

D. METHOD USED:

	Suction	Suction & Curretage	Saline	Saline & Curretage	D&C	Hysterotomy
In patient		5	3	4	1	1
Out patient	16	19	1		22	

E. NO—UNKNOWN

F. NO—UNKNOWN

G. NO—UNKNOWN

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PLAINTIFFS' EXHIBIT 48

STATEMENT BY C. WILLIAM KECK, M.D., M.P.H., TO AKRON CITY COUNCIL HEALTH & SOCIAL SERVICE COMMITTEE, DATED FEBRUARY 4, 1978, WITH ATTACHED ARTICLE

HEARING
HEALTH AND SOCIAL SERVICE COMMITTEE
AKRON CITY COUNCIL

PROPOSED ABORTION ORDINANCES

February 4, 1978

By: C. William Keck, M.D., M.P.H.
Director of Health
Akron Health Department
177 South Broadway
Akron, Ohio 44308

Mr. Goehler and members of the Committee, I want to thank you for the opportunity to comment on the proposed abortion legislation now before you. As you know, my name is Dr. C. William Keck and I'm the Director of the Akron Public Health Department.

The ordinances in question propose to regulate the functioning of abortion clinics and other surgical facilities in the City of Akron where procedures are performed that have "an inherent risk to the life or health of the patient comparable to that of abortion". All surgical facilities are included, but hospitals are included only for the regulation of abortions and they would not be required to have a City license. According to the proposed ordinances, the responsibility of the Akron Department of Health would include:

(1.) the promulgation of rules and regulations governing each procedure fitting the risk definition,

including the delineation of which surgical procedures might be exempted from the standards of the ordinance and which must be included.

(2.) making available to all licensed physicians performing abortions in the City of Akron constructive notice forms, consent forms in triplicate, abortion report forms, complication report forms, and a list of public and private agencies available to assist a woman during pregnancy if she chooses not to have an abortion.

(3.) collecting all abortion and complication reports and collating and evaluating data contained therein.

(4.) inspecting all surgical facilities covered by the ordinance biannually, and reviewing their medical records and facilities.

(5.) licensing all surgical facilities covered by the ordinance and collecting license fees.

(6.) holding hearings to determine why a license should not be revoked from a facility in violation of the ordinance.

It becomes rapidly apparent that the Akron Health Department would be the major instrument intended to carry out the parameters of the proposed ordinances should either be adopted, and it's on that basis that I would like to speak on two major issues, the necessity for regulation of abortion facilities and the realities of what regulation of other surgical procedures of comparable risk to abortion would mean to my Department and this City's government.

I think it's appropriate to begin by stating that health departments have long played a role in regulating facilities where their operation has been shown to provide a

measurable threat to the public's health. Examples in the Akron area would include restaurants, where the potential for spread of infectious disease is high, and plasma collection centers where inordinate hepatitis transmission has occurred in the past. Indeed, the Health Commission of the City of Akron, through the Health Department and its Director, currently has full authority to deal with all matters concerning the public health and sanitation, including the regulation of medical and surgical facilities if the need were shown to exist (See Section 79 of the Charter of the City of Akron). In other words, if a medical necessity for regulation of abortion or other surgical facilities existed, a new ordinance would not be necessary to attempt to deal with that health problem, even though the Akron Health Department has not been traditionally involved in regulating private medical practice.

As you know, I've not approached the Health Commission with the suggestion that they should consider the formal regulation of abortion facilities. I have not done that because I don't believe that the medical necessity for regulation suggested by the proposed ordinances exists in Akron, and I think it important that I outline for you the reasons for that belief. I know that the Committee has listened to many hours of testimony from a number of experts, often presenting conflicting points of view, and, in some areas, without presenting appropriate corroborative data. My position is based on what I believe is a sound data base. I've summarized it below, and have also included a bibliography at the end of the text as well as copies of the most salient articles. That will allow you to peruse them at your leisure to assure yourself of the accuracy of my summation and to have available to you other pertinent information that

I've not summarized in the text. The major points of my position are as follows:

1. Once a woman becomes pregnant, there are only two conscious choices possible for her to make relative to the outcome of that pregnancy; carrying the pregnancy to term or aborting the pregnancy. Each choice carries its own inherent risk.

2. Abortion is a relatively simple and legal surgical procedure performed by duly licensed specialist physicians in the Akron area.

3. Abortion, particularly 1st trimester abortion, carries with it a low risk of death, a lesser risk of death to the woman involved than carrying a pregnancy to full term, and a risk of death that has been diminishing over the past few years. I refer to data principally from the Joint Program for the Study of Abortion/Center for Disease Control (JPSA/CDC)—an ongoing prospective study of legally induced abortions in the United States that I believe constitutes the largest study of abortion reported to date.

* * *

4. Legal abortions in abortion clinics have been available in Summit County since late 1976. There has been one maternal death in Summit County during that period due to amniotic fluid embolism after delivery of a live infant. There have been no maternal deaths related to legal abortions.

Table IV(4)
Maternal mortality from all causes (including legal abortion) in Summit County by year

Year	*No. of Maternal Deaths*
1971	0
1972	0
1973	0

Year	*No. of Maternal Deaths*
1974	1
1975	0
1976	0
1977[5]	1*

* Applies to Akron only.

5. Morbidity rates associated with abortion, particularly during the first trimester, are relatively low in the United States, and lower than the United States average in the Akron area.

MORBIDITY

Table V[6]

Rate of complications per legal abortions done by suction curretage during the 1st trimester JPSA/CDC, 1971-1975

	Weeks of Gestation		
Rates	*8*	*9-10*	*11-12*
Total morbidity rate*	4.55	4.81	5.47
Major morbidity rate†	0.23	0.36	0.44

* Includes nearly 100 potentially codable complications, covering even such relatively minor complaints as breast engorgement and vaginitis.

† Includes the following 15 major complications: Cardiac arrest; convulsions; death; endotoxic shock; fever for 3 or more days; hemorrhage necessitating blood transfusions; hypernatremia; injury to bladder, ureter or intestines; pelvic infection with 2 or more days of fever and a peak of at least 40° C, or with hospitalization for 11 or more days; pneumonia; ostcgiatric hospitalization for 11 or more days; pulmonary embolism or infarction; thrombophlebitis; unintended major surgery; and wound disruption after hysterotomy or hysterectomy.

Table VI[7]

Number of abortions and complications, and rate of complications per 100 legal abortions done during the 1st trimester in Akron's four abortion clinics during 1977

Abortions Done	5,574	
Total Complications	40	
Major Complications	1	(Convulsion in an epileptic)
Total Morbidity Rate	0.71	
Major Morbidity Rate	0.02	

Note: Information was not requested by week of gestation. Many of the very minor complications (e.g., breast tenderness) counted in the JPSA/CDC study were not counted in Akron so the total morbidity rate above, while appropriate for here, is artifically low compared to the National figures in Table V. The major morbidity rates are comparable, however, except that the National figures are more than two years old and may very well be lower now. In any case the Akron rate could hardly be lower.

6. The State of Ohio currently regulates abortion facilities in the City of Akron.

7. There have been few medical problems associated with the operation of Akron's abortion facilities. Several complaints have been investigated by the Akron Health Department and the Summit County Medical Society. They had either no apparent substance or were easily resolved. There have also been no medical malpractice suits in Akron about abortions.

In summary, then, I must suggest to the Committee that from the point of view of protecting the health of the woman involved there is no compelling reason to regulate Akron's abortion facilities. If data exists of sufficient quality to contradict that which is available to me, I'd be pleased to evaluate it. I only hope it would come in sufficient detail to permit careful analysis from an epidemiological point of view.

The second major issue I'd like to address is the provisions of the second abortion ordinance submitted to City Council for consideration that deal with the licensure and regulation of surgical facilities where procedures are performed that have "an inherent risk to the life or health of the patient comparable to that of abortion". The potential impact of that provision on the Department of Health is so staggering that I find myself somewhat at a loss in deciding how to approach the whole area. Let me begin by discussing the need for such an approach, follow that with a brief discussion of what would be necessary in order for the Health Department to comply with it and end with my views of what the impact of an effort like this would be.

Try as I may, I cannot discern a health problem that would require such an effort for its resolution. We all happen to live in an area whose overall medical capacity in terms of facilities, equipment and personnel is quite excellent. We have a new medical school which is stimulating further excellence and a Health Systems Agency and Goals for Greater Akron Health Task Force that have both spent years looking at our local health care delivery system without ever suggesting in their health plans the existence of a problem in quality of delivery of health care that would require this kind of activity for its resolution. Nor have recent Health Department community diagnosis and priority planning efforts identified a need to regulate outpatient surgical procedures executed by competent, licensed practitioners.

* * *

When you realize that there are 268 physician and dentist subspecialists practicing in Akron who may perform one or more of many surgical procedures in their offices with risk comparable to abortion (see Table VII),

you can begin to realize the potential size and nature of such an undertaking. The Health Department has no real expertise in these clinical subspeciality areas—we would have to hire it. The Health Department has no inspectors with free time who could be trained to do inspections—we would have to hire them. The Health Department has no infrastructure to handle the clerical needs of such an effort, we would have to create it. The cost in dollars would be staggering, and the potential licensure income of approximately $25,000 would barely scratch the surface of those costs. The Non-Institutional Services Division of the Ambulatory Health Care Program of the Ohio Department of Health which inspects agencies for Medicaid that deliver home nursing care just determined that, including all administrative and inspectional costs, it costs $1,500.00 to make *one* agency inspection. Costs of that magnitude multiplied by an unknown number of procedures done by dozens of facilities lead quickly into a range of hundreds of thousands of dollars per year. Even if money in large amounts was immediately available, it could easily take a year or more for the first license to be issued. There would be other costs as well. Such an effort would sap the energy of a significant portion of the Health Department managerial team; a carefully engineered Management by Objectives and Results system and its structure of public health priorities would fall by the wayside to deal with inappropriate priorities; an unnecessary antagonistic mileu would be created between City government and the medical community; and the Health Department's effectiveness as a regulatory agency would be seriously damaged, to name just a few. In actuality, I think we would quickly find many provisions of the ordinance impossible to fulfill.

PLAINTIFFS' EXHIBIT 47

AKRON GENERAL MEDICAL CENTER REPORT ON ABORTIONS
August 25, 1978

OUTPATIENT ABORTIONS

Date	*Elective*	*Therapeutic*	*First Trimester*	*Method*
May 1977	4	1	5	Suction Curettage (5)
June 1977	3	0	3	Suction Curettage (3)
July 1977	1	0	1	Suction Curettage (1)
August 1977	0	0	0	0
September 1977	3	0	3	Suction Curettage (3)
October 1977	3	0	3	Suction Curettage (3)
November 1977	2	0	2	Suction Curettage (2)
December 1977	3	0	3	Suction Curettage (3)
January 1978	0	0	0	0
February 1978	6	2	8	Suction Curettage (8)
March 1978	1	0	1	Suction Curettage (1)
April 1978	2	0	2	Suction Curettage (2)
Total	28	3	31	31

/s/ Nancy L. Walker, A.R.T.
Acting Medical Record Administrator

INPATIENT ABORTIONS

Date	*Elective*	*Therapeutic*	*1st Trimester*	*2nd Trimester*	*Method*
May 1977	0	0	0	0	0
June 1977	0	0	0	0	0
July 1977	1	0	1	0	Suction Curettage
	1	0	1	0	Hysterotomy
August 1977	3	0	3	0	Suction Curettage (3)
September 1977	2	0	2	0	Suction Curettage (2)
	0	1	0	1	Saline Injection
	0	1	1	0	Dilatation & Curettage
	0	1	0	1	Dilatation & Curettage
October 1977	2	0	2	0	Suction Curettage (2)
November 1977	1	0	1	0	Suction Curettage
December 1977	4	0	3	1	Suction Curettage (4)
January 1978	0	0	0	0	0
February 1978	4	0	4	0	Suction Curettage (4)
	0	1	1	0	Abdominal Hysterectomy

***Inpatient Abortions**, continued:*

Date	*Elective*	*Therapeutic*	*1st Trimester*	*2nd Trimester*	*Method*
March 1978	2	0	2	0	Suction Curettage (2)
April 1978	1	0	1	0	Suction Curettage
	0	2	2	0	Suction Curettage (2)
Total	21	6	24	3	27

Total number of cases by Method — Suction Curettage — 22
Hysterotomy — 1
Saline Injection — 1
Abdominal Hysterectomy — 1
Dilatation & Curettage — 2
27

/s/ Nancy L. Walker, ART
Acting Medical Record Administrator

The impact of such an effort could only be a negative one. The authority to regulate in the area of public health needs is a powerful tool for correcting public health problems that won't respond to other measures. To regulate without cause is a flagrant misuse of regulatory authority and would not, in this instance, improve our health care delivery system.

Table VII
Physicians and dentists within the City of Akron who may perform surgeries outside the hospital

Cardiovascular Surgery	7
Dermatology	7
Diagnostic Radiology	7
Eye, Ear, Nose & Throat	1
Ear, Nose & Throat	0
Gynecology	2
Gynecologic Oncology	1
General Surgery	29
Industrial Surgery	1
Oncology	2
Obstetrics & Gynecology	36
Occupational Medicine	9
Ophthalmology	13
Orthopaedic Surgery	26
Otolaryngology	6
Otorhinolaryngology	2
Pediatrics	18
Pediatric Cardiology	2
Pediatric Surgery	3
Pediatric Urology	1
Pediatric Orthopaedic Surgery	1
Proctology	1

Plastic Surgery	9
Radiology	22
Reconstructive Surgery	3
Traumatic Surgery	0
Thoracic Surgery	6
Vascular Surgery	3
Urology	13
Oral Dental Surgeons	11
Podiatry	23
Osteopathy—Obstetrics	1
Osteopathy—Surgery	2
	268

* * * My suggestion to the Committee and City Council is that from the point of view of the health of the woman there is no demonstrable medical need for action and the surgical facility regulation provisions are unnecessary and basically unworkable. I believe City Council would be ill advised to pass either of these abortion ordinances.

1. THE EFFECT OF DELAY AND METHOD CHOICE ON THE RISK OF ABORTION MORBIDITY

By Willard Cates, Jr., Kenneth F. Schulz, David A. Grimes and Carl W. Tyler, Jr.

* * *

Relative Risks of Delay and Methods

Within the first 12 weeks, the main risk to a woman who wants an abortion results from delay. Both total and major morbidity rates are lowest when abortions are performed by suction curettage at eight or fewer menstrual weeks' gestation (see Table 2). The total

complication rate for suction curettage performed at eight or fewer weeks is 4.55 per 100 abortions, compared with 4.81 and 5.47 if the same procedure is delayed until the next two intervals (9–10 and 11–12 weeks). Thus, the total morbidity rate increases by 20 percent when abortion is delayed from the eighth to the twelfth week of gestation.

The major complication rate is 0.23 per 100 abortions for suction curettage at eight or fewer weeks, compared with 0.36 in the 9–10-week interval and 0.44 if the patient waits until the 11–12-week interval. Thus, the major complication rate increases 91 percent when abortion is postponed from the eighth to the twelfth week.

* * *

Intillation procedures, whether using saline or PCF_{2a} as the abortifacient, were associated with significantly higher total and major morbidity rates than abortions performed by uterine evacuation techniques. The total complication rate associated with abortions performed by saline instillation was higher during the first weeks of the second trimester than for terminations performed after the sixteenth week. The major morbidity rates for saline induction increased with length of gestation; however, this was an inconsequential increase. Instillation of PCF_{2a} was associated with total and major complication rates that were higher than those associated with saline instillation during both of the gestational intervals studied.

* * *

1. Delay

Our findings clearly demonstrate that *any* delay increases the risk of complications to a pregnant woman who wishes an abortion. Moreover, this risk appears to increase continuously and linearly as the length of

gestation increases. Considering D&E an extension of the uterine evacuation procedures used at 12 weeks or less, the risk of complications in the 13-16-week interval increases at a rate similar to that in the earlier period. Through 16 weeks' gestation, we have shown conceptually how even one week's delay (at whatever stage of gestation the woman initially requests her abortion) will add increased risks.

Previous reports on the correlates of abortion delay have focused on differences between women seeking first- and second-trimester abortions. However, based on the above reasoning, we feel this differentiation by trimesters is arbitrary and can be misleading. Our data show that a two-week delay between the ≤8 and 9-10-week intervals is just as dangerous as a similar delay between the 11-12- and 13-16-week intervals. We believe that gestation as a risk factor should be viewed as a *continuum* and not in terms of arbitrary stratifications, and that public education should emphasize that the earlier a woman can obtain an abortion, the lower her risks.

* * *

2. Choice of Method

JPSA/CDC reveals that in those institutions studied, the method chosen for later abortions affected both total and major morbidity.[10] D&E was more than 160 percent safer than saline instillation, which in turn was 60 percent safer than PGF_{2a} instillation. Both these differences were statistically significant ($p < 0.01$), and remained significant even after standardizing for age of patient, gestational age, preexisting conditions, level of operator training, prophylactic antibiotics and patient follow-up. Therefore, our study documents that D&E *can* be relatively safe, and perhaps it is time to train

specialists in D&E procedures so that this method will be available in selected facilities everywhere.

Acceptance of the relative safety of midtrimester D&E will reduce complications from abortion in two ways: First, the method itself appears to be safer; and second, there will be no need for the traditional waiting period. Current clinical teachings often advise women seeking abortion who are 13–15 weeks pregnant to wait another 2–4 weeks until the uterus is large enough for abdominal amniocentesis.[11] This delay is not necessary, however, if D&E is used to terminate pregnancies at the time the women seek their abortions. Extrapolating from JPSA/CDC to national data, we estimate that less than one percent of all abortions would be performed at more than 16 weeks if no waiting period were imposed, and that 90 percent of all instillation procedures would be replaced by D&E procedures between the thirteenth and sixteenth weeks.

Finally, our model provides a summary for both health professionals and patients of the risks of complications inherent in delay and in choice of abortion method. We hope that an awareness of these cumulative risks will lead to a reduction of delay in seeking abortion, and an increase in the choice of the safest method.

* * *

PLAINTIFFS' EXHIBIT 50

STATEMENT ON ABORTION ORDINANCES BY DR. CHARLES BOWEN, SPEAKING FOR THE SUMMIT COUNTY MEDICAL SOCIETY

I am Dr. Charles Bowen and I am engaged in the private practice of Obstetrics and Gynecology. I am representing the Summit County Medical Society Council as secretary and as a member of the Maternal and Infant Health Committee of Summit County Medical Society (SCMS).

After the Supreme Court ruling on abortions in 1973, the SCMS Council approved guidelines for the supervision of non-therapeutic abortion clinics drawn up by the Maternal & Infant Health Committee and the Public Health Committee of SCMS realizing that the enforcement of these guidelines could be difficult. However, since the local abortion clinics have opened they have voluntarily allowed an audit and review committee of the SCMS and the Akron Health Department and the Akron Ob-Gyn Society to enter their clinics. The initial reviews were carried out by Doctors Estep, Keck and Bowen in June 1977. There have been a few deficiencies in the different clinics that had been corrected by the time we had a follow-up inspection. The Planned Parenthood Association also insists on inspecting the clinics before they will refer patients. Their inspection is thorough on all aspects mentioned in the ordinance. The few complaints SCMS has received from patients of the abortion clinics were all thoroughly investigated and settled to everyone's satisfaction.

Therefore, there is no medical need for an ordinance to be introduced.

The SCMS really became concerned when the amended ordinance would have control of abortion clinics and all

comparable surgical clinics. There is no doubt this would be an interference in the private practice of medicine. No third party is allowed to invade the privacy of the physician-patient relationship. The tendency for government interference at all levels into the practice of medicine has become alarming in the past few years.

The Ohio Medical Practice Act as amended in 1969, is the legislation which placed the authority over the practice of medicine and surgery in the hands of the Ohio Medical Board. In the Medical Practice Act sections 4730.01 thru section 4731.99 gives the Ohio Medical Board the authority to regulate the practice of Medicine and Surgery and eleven other limited branches of health practice. This authority is not given to any other level of government in the state. The SCMS was not asked for any professional advice by the proposers of this ordinance.

The physicians of the SCMS are only interested in making sure that all abortion clinics in Summit County are well run from a medical viewpoint and up to this point in time the abortion clinics are doing an adequate job.

The ordinance seems to indicate that the Health Department under Dr. Keck, would develop an ongoing medical audit of all comparable surgical clinics. This is not necessary and as a tax payer I would certainly be interested in knowing the cost of such a program which could include as many as 200 clinics. The Health Commission appointed by the mayor and approved by City Council should be able to do any regulating that may become necessary if we should fail.

The physicians of Summit County do not intend to be drawn into the debate as to whether elective abortions are right or wrong. However, when there is an attempt

to pass an ordinance to regulate abortion clinics which at the same time would infringe on the private practice of medicine we will take a strong, vigorous stand against that ordinance. We did not realize that the ordinance would be amended as it was or we would have spoken out against it much sooner.

City council proposed an ordinance on abortion clinics in October 1977, on which several physicians testified and on the advice of the law director, the ordinance was not passed.

The medical community recognizes that non-therapeutic abortions are legal. We believe that it is our responsibility to determine that the clinics are run ethically and that they will stand medical inspection for standards and quality.

PLAINTIFFS' EXHIBIT 51

STATEMENT BY AKRON MAYOR JOHN S. BALLARD, DATED MARCH 8, 1978, ON HIS DECISION TO ALLOW ORDINANCE NO. 160-1978 TO BECOME LAW WITHOUT HIS SIGNATURE

Although I have serious reservations about the abortion ordinance, I have decided to allow it to become law without my signature.

My reservations are based upon a failure to demonstrate that a need exists for further regulation. I understand that the State inspects the existing clinics under the Medicaid program to insure they meet adequate medical standards. I don't believe any credible evidence has been advanced to suggest that adequate and proper medical standards and procedures are being ignored in Akron.

Therefore, I don't believe it has been demonstrated, from a medical standpoint, that further regulation is necessary.

Further, it appears to me that the thrust of this ordinance may run counter to now well-established case law, in that it possibly invades constitutionally guaranteed rights of women who desire to have an abortion.

There has been considerable debate about the legality and constitutionality of the ordinance. I don't feel I should presume to decide these questions—the courts are the proper place for the resolution of questions of law.

If I veto the ordinance, the legal debate will no doubt go on *ad infinitum*. Without question, when the ordinance becomes law in 30 days, it will be challenged in the courts.

It appears to me that only through litigation will the matter be put to rest one way or the other with finality.

DEPOSITION OF MARVIN WEINBERGER

[39] Q. All right. Let's try to do it this way. You made a statement, in that article identified as Plaintiffs' Exhibit 5, that "These experts set out to devise an ordinance worthy of becoming a national model, and are convinced that they have succeeded in developing legislation which will fairly and constitutionally regulate abortion to protect the health and safety of the mother, while insofar as possible preserving the right to life of the unborn child."

Is that an accurate statement?

* * *

Q. Marvin made that representation in this article that that's what their interest was in assisting in drafting and reviewing the Akron ordinance, and I want to know if that's an accurate summary of their interest in the ordinance.

A. My perception of their interest—

Q. Yes?

A. —I think, can be fairly summarized as I summarized it in that article.

* * *

[40] Q. All right. Have you ever visited any of the three abortion clinics in Akron, visited, been on the premises, inside any of the clinics?

* * *

The Witness: I don't recall having ever entered into any of the three abortion clinics.

* * *

Q. Have you ever witnessed any counseling sessions in the clinic, in any of the three clinics?

A. If I have never visited any of the clinics—

Q. Yes or no?

A. No.

* * *

[41] Q. It seems pretty clear. Do you have any personal knowledge, through your own observations, not hearsay, of what somebody has told you about what goes on in the clinics, but through your own personal observations do you have any knowledge of the kinds of counseling or medical services available at the clinics?

* * *

[42] *The Witness:* No.

* * *

[98] Q. All right. Did you have any other basis of knowing about what went on in the clinics?

* * *

Beyond that, we had, on one occasion, a confidential witness appear before Councilman Goehler and some of the other people for our side, who worked at one of the local hospitals, who complained about specific problems that she had perceived in terms of physiological reactions to abortions that she had to treat.

Q. Now, is this before the committee on Health and [99] Social Services headed by Councilman Goehler?

A. Right.

Q. And was the entire committee there for that meeting?

A. For that particular meeting? I should correct myself, I don't believe it was a formal committee meeting. It was held outside of Council chambers because of the extreme concern of the particular party not to be identified for various reasons.

* * *

A. At this more or less informal meeting, I was there. We had—we—we, after having found out this person was interested in speaking, we—we made contact with committee and asked if they were interested in hearing from this person, or specifically Bob Goehler, and he agreed to take the time to come over and hear what this woman had to say.

* * *

OHIO REV. CODE ANN.
§§ 2151.03, 2151.04, 2151.05, 2151.23, 2151.33, 2317.54, 2919.12, AND 3109.04

§ 2151.03 Neglected child defined

As used in sections 2151.01 to 2151.54, inclusive, of the Revised Code, "neglected child" includes any child:

(A) Who is abandoned by his parents, guardian, or custodian;

(B) Who lacks proper parental care because of the faults or habits of his parents, guardian, or custodian;

(C) Whose parents, guardian, or custodian neglects or refuses to provide him with proper or necessary subsistence, education, medical or surgical care, or other care necessary for his health, morals, or well being;

(D) Whose parents, guardian, or custodian neglects or refuses to provide the special care made necessary by his mental condition;

(E) Whose parents, legal guardian, or custodian have placed or attempted to place such child in violation of sections 5103.16 and 5103.17 of the Revised Code.

A child who, in lieu of medical or surgical care or treatment for a wound, injury, disability, or physical or mental condition, is under spiritual treatment through prayer in accordance with the tenets and practices of a well-recognized religion, is not a neglected child for this reason alone.

§ 2151.04 Dependent child defined

As used in sections 2151.01 to 2151.54, inclusive, of the Revised Code, "dependent child" includes any child:

(A) Who is homeless or destitute or without proper

care or support, through no fault of his parents, guardian, or custodian;

(B) Who lacks proper care or support by reason of the mental or physical condition of his parents, guardian, or custodian;

(C) Whose condition or environment is such as to warrant the state, in the interests of the child, in assuming his guardianship.

§ 2151.05 Child without proper parental care

Under sections 2151.01 to 2151.54 of the Revised Code, a child whose home is filthy and unsanitary; whose parents, stepparents, guardian, or custodian permit him to become dependent, neglected, abused, or delinquent; whose parents, stepparents, guardian, or custodian, when able, refuse or neglect to provide him with necessary care, support, medical attention, and educational facilities; or whose parents, stepparents, guardian, or custodian fail to subject such child to necessary discipline is without proper parental care or guardianship.

§ 2151.23 Jurisdiction of juvenile court

(A) The juvenile court has exclusive original jurisdiction under the Revised Code:

(1) Concerning any child who on or about the date specified in the complaint is alleged to be a juvenile traffic offender, delinquent, unruly, abused, neglected, or dependent;

(2) To determine the custody of any child not a ward of another court of this state;

(3) To hear and determine any application for a writ of habeas corpus involving the custody of a child;

(4) To exercise the powers and jurisdiction given

the probate division of the court of common pleas in Chapters 5122. and 5123. of the Revised Code, if the court has probable cause to believe that a child otherwise within the jurisdiction of the court is a mentally ill person subject to hospitalization by court order, as defined in section 5122.01 of the Revised Code, or a mentally retarded person subject to hospitalization by court order as defined in section 5123.68 of the Revised Code;

(5) To hear and determine all criminal cases charging adults with the violation of any section of Chapter 2151. of the Revised Code;

(6) Under the interstate compact on juveniles in section 2151.56 of the Revised Code;

(7) To hear and determine applications for consent to marry pursuant to section 3101.04 of the Revised Code.

(B) The juvenile court has original jurisdiction under the Revised Code:

(1) To hear and determine all cases of misdemeanors charging adults with any act or omission with respect to any child, which act or omission is a violation of any state law or any municipal ordinance;

(2) To determine the paternity of any child alleged to have been born out of wedlock pursuant to Chapter 3111. of the Revised Code;

(3) Under the uniform support of dependents act in Chapter 3115. of the Revised Code.

(C) The juvenile court, except as to juvenile courts which are a separate division of the court of common pleas, or a separate and independent juvenile court, has jurisdiction to hear, determine, and make a record of any action for divorce or alimony involving the custody or care of children filed in the court of common pleas

and certified by the court of common pleas with all the papers filed therein to the court for trial, provided that no such certification shall be made to any court unless the consent of the juvenile judge is first obtained. After such certification is made and consent obtained, the court shall proceed as if such action were originally begun in said court except as to awards for alimony or support due and unpaid at the time of certification, over which the court has no jurisdiction.

(D) The juvenile court has jurisdiction to hear and determine all matters as to custody and support of children duly certified by the court of common pleas to the juvenile court after a divorce decree has been granted, including jurisdiction to modify the judgment and decree of the common pleas court as the same relate to the custody and support of children.

(E) The juvenile court has jurisdiction to hear and determine the case of any child certified to the court by any court of competent jurisdiction if such child comes within the jurisdiction of the court as defined by this section.

(F) The juvenile court shall exercise its jurisdiction in child custody matters in accordance with sections 3109.21 to 3109.36 of the Revised Code.

§ 2151.33 Temporary care; emergency medical treatment; reimbursement

Pending hearing of a complaint filed under section 2151.27 of the Revised Code and service of citations, the juvenile court may make such temporary disposition of any child as it deems best. Upon the certificate of one or more reputable practicing physicians, the court may summarily provide for emergency medical and surgical treatment which appears to be immediately necessary for any child concerning whom a complaint or an application

for care has been filed, pending the service of a citation upon its parents, guardian, or custodian. The court may order the parents, guardian, or custodian, if found able to do so, to reimburse the court for the expense involved in providing such emergency medical and surgical treatment, and any such person who disobeys such order may be adjudged in contempt of court and punished accordingly.

When such emergency medical and surgical treatment is furnished a child who is found at the hearing to be a nonresident of the county, and if the expense of such medical and surgical treatment cannot be recovered from the parents, legal guardian, or custodian of such child, the board of county commissioners of the county in which such child has a legal settlement shall reimburse the court for the reasonable cost of such emergency medical or surgical treatment out of its general fund.

§ 2317.54 [Consent to surgical or medical procedure; requirements.]

A hospital shall not be held liable for a physician's failure to obtain an informed consent from his patient prior to a surgical or medical procedure or course of procedures, unless the physician is an employee of the hospital.

Written consent to a surgical or medical procedure or course of procedures shall, to the extent that it fulfills all the requirements in divisions (A), (B), and (C) of this section, be presumed to be valid and effective, in the absence of proof by a preponderance of the evidence that the person who sought such consent was not acting in good faith, or that the execution of the consent was induced by fraudulent misrepresentation of material facts, or that the person executing the consent was not

able to communicate effectively in spoken and written English or any other language in which the consent is written. Except as herein provided, no evidence shall be admissible to impeach, modify, or limit the authorization for performance of the procedure or procedures set forth in such written consent.

(A) The consent sets forth in general terms the nature and purpose of the procedure or procedures, and what the procedures are expected to accomplish, together with the reasonably known risks, and, except in emergency situations, sets forth the names of the physicians who shall perform the intended surgical procedures.

(B) The person making the consent acknowledges that such disclosure of information has been made and that all questions asked about the procedure or procedures have been answered in a satisfactory manner.

(C) The consent is signed by the patient for whom the procedure is to be performed, or, if the patient for any reason including, but not limited to, competence, infancy, or the fact that, at the latest time that the consent is needed, the patient is under the influence of alcohol, hallucinogens, or drugs, lacks legal capacity to consent, by a person who has legal authority to consent on behalf of such patient in such circumstances.

Any use of a consent form that fulfills the requirements stated in divisions (A), (B), and (C) of this section has no effect on the common law rights and liabilities, including the right of a physician to obtain the oral or implied consent of a patient to a medical procedure, that may exist as between physicians and patients on July 28, 1975.

As used in this section the term "hospital" has the meaning set forth in division (D) of section 2305.11 of

the Revised Code. The provisions of this division apply to hospitals, doctors of medicine, doctors of osteopathic medicine, and doctors of podiatric medicine.

§ 2919.12 Abortion without informed consent prohibited

(A) No person shall perform or induce an abortion without the informed consent of the pregnant woman.

(B) If the pregnant woman is an unmarried minor, the pregnant woman's consent must be accompanied by the informed consent of one of her parents or of her custodian or guardian.

(C) Whoever violates this section is guilty of consensual abortion, a misdemeanor of the first degree and for subsequent offense, a felony of the fourth degree; and is liable to the pregnant woman for civil compensatory and exemplary damages.

§ 3109.04 Court awarding custody; joint custody; modifications; best interests of child

Note: See also preceding amendment of this section by 1981 H 71, in effect until 3-15-82.

(A) Upon hearing the testimony of either or both parents and in accordance with sections 3109.21 to 3109.36 of the Revised Code, the court shall decide to whom the care, custody, and control of the children shall be given. The court may grant the care, custody, and control of the children to either parent or, if a request is made in accordance with division (D) of this section, to the parents jointly. The court shall take into account that which would be in the best interest of the children. The court may allow any child who is twelve years of age

or older to choose, in an original proceeding on custody and in a proceeding for modification of a prior custody order of the court, the parent with whom the child is to live, unless the court finds that the parent so selected is unfit to take charge or unless the court finds, with respect to a child who is twelve years of age or older, that it would not be in the best interest of the child to have the choice. The court shall not grant joint care, custody, and control of the children to the parents unless they request the grant of joint care, custody, and control pursuant to division (D) of this section.

If the court allows any child who is twelve years of age or older to choose the parent with whom the child is to live, the court shall offer the child the opportunity to inform the court of the choice in chambers or in open court. If the child elects to inform the court of the choice in chambers, no persons other than the child, the child's attorney, the judge, any necessary court personnel, and, in the judge's discretion, the attorney of each parent shall be permitted to be present in the chambers when the child informs the court of the choice and is questioned with respect to the choice.

Prior to trial, the court may cause an investigation to be made as to the character, family relations, past conduct, earning ability, and financial worth of the parties to the action and may order the parties and their minor children to submit to medical, psychological, and psychiatric examinations. The report of the investigation and examinations shall be made available to either party or his counsel of record not less than five days before trial, upon written request. The report shall be signed by the investigator and the investigator shall be subject to cross-examination by either party concerning the contents of the report. The court may tax as costs all or any part of the expenses for each investigation.

The court may order that the parents have joint care, custody, and control of the children only if both parents request joint custody and file a plan for joint custody pursuant to division (D) of this section and if joint custody is in the best interest of the children. Upon the filing of a plan requesting the joint care, custody, and control of the children, the court shall review the parents' plan for joint custody to determine if the plan is in the best interest of the children. If the court determines that the plan is in the best interest of the children, the court shall approve the plan. If the court determines that the plan or any part of the plan is not in the best interest of the children, the court shall require the parents to make appropriate changes to the plan to meet the court's objections to the plan. If changes to the plan are made to meet the court's objections, and if the new plan is in the best interest of the children, the court shall approve the plan. If changes or if the parents attempt to make changes to the plan to meet the court's objections, but the court determines that the new plan or any part of the new plan still is not in the best interest of the children, the court may reject the parents' request for joint care, custody, and control of the children and proceed as if the request had not been made. A plan approved by the court under this division shall be incorporated into a provisional joint custody decree granting the parents the provisional joint care, custody, and control of the children. The provisional joint custody decree shall clearly state that it is provisional, that it may be modified at any time prior to sixty days after the date of its issuance, and that it is subject to termination at any time prior to ninety days after the date of its issuance upon motion of either parent or, in certain situations, upon motion of the court itself, that if either parent or the court itself makes such a motion, the court

is required to terminate the provisional joint custody decree and proceed as if no request for joint custody ever had been made, and that if neither parent nor the court itself makes such a motion prior to the expiration of the niety-day [*sic*] period, the provisional joint custody decree immediately and without need for further action becomes final on the ninetieth day after the date of its issuance, subject to modification or termination authorized by this section. Any such provisional joint custody decree shall be appended to, but shall be separate and independent from and shall not affect the final decree of dissolution, divorce, separation, annulment, or alimony arising out of the action out of which the question of care, custody, and control arose.

If the court finds, with respect to any child under eighteen years of age, that custody to neither parent is in the best interest of the child, it may commit the child to a relative of the child or certify a copy of its findings, together with as much of the record and the further information, in narrative form or otherwise, as it deems necessary or that the juvenile court requests, to the juvenile court for further proceedings, and, upon the certification, the juvenile court has exclusive jurisdiction.

(B)(1) Except as provided in division (B)(2) of this section, the court shall not modify a prior custody decree unless it finds, based on facts that have arisen since the prior decree or that were unknown to the court at the time of the prior decree, that a change has occurred in the circumstances of the child, his custodian, or either joint custodian, and that the modification is necessary to serve the best interst [*sic*] of the child. In applying these standards, the court shall retain the custodian or both of the joint custodians designated by the prior decree, unless one of the following applies:

(a) The custodian or both joint custodians agree to a change in custody.

(b) The child, with the consent of the custodian or of both joint custodians, has been integrated into the family of the prson seeking custody.

(c) The child's present environment endangers significantly his physical health or his mental, moral, or emotional development and the harm likely to be caused by a change of environment is outweighed by the advantages of the change of environment to the child.

(2) In addition to the modification authorized under division (B)(1) of this section:

(a) Joint custodians may modify the terms of the plan for joint care, custody, and control approved by the court and incorporated by it into the joint custody decree. Modifications may be made under this division, in relation to a final decree, at any time, and in relation to a provisional decree, at any time prior to sixty days after the date of issuance of the provisional decree. The modifications to the plan shall be filed with the court, and the court shall include them in the plan, unless they are not in the best interest of the children, in which case the court may reject the modifications. Modifications submitted by the joint custodians shall be effective upon their inclusion by the court in the plan. A modification to a provisional plan madeunder [*sic*] this division does not affect or extend the ninety-day period during which the provisional plan may be terminated upon motion of either parent or the court itself.

(b) The court may modify the terms of the plan for joint care, custody, and control approved by the court and incorporated by it into the joint custody decree upon the request of one or both of the joint custodians. Modifications may be made under this

division, in relation to a final decree, at any time, and in relation to a provisional decree, at any time prior to sixty days after the date of issuance of the provisional decree. The court shall not make any modification to the plan, unless the modification is in the best interest of the children and the joint custodians agree to the modification. A modification to a provisional plan made under this division does not affect or extend the ninety-day period during which the provisional plan may be terminated upon motion of either parent or the court itself.

(c) The court shall terminate a provisional joint custody decree [*sic*] if either parent or the court itself makes a motion to terminate the provisional decree at any time prior to ninety days after the date of its issuance. The court itself may make a motion to terminate a provisional decree only if it has reason to believe that the plan incorporated into the provisional decree is not in the best interest of the children and that it cannot be modified so as to be in the best interest of the children or if it has reason to believe that joint custody itself is not in the best interest of the children. If the court has reason to believe that the plan incorporated into the provisional decree is not in the best interest of the children but that it can be modified so as to be in the best interest of the children, the plan may be modified in accordance with division (B)(2)(a) or (b) of this section regardless of whether the sixty-day period that normally applies in relation to modification of provisional decrees under those divisions has expired. If a provisional decree is terminated under this division, the court shall proceed in accordance with division (B)(2)(e) of this section. If neither parent nor the court itself makes a motion to terminate a provisional decree prior to the expiration of the ninety-day period, the provisional

decree immediately and without need for further action shall become final on the ninetieth day after the date of its issuance, subject to modification and termination authorized by this section.

(d) The court may terminate a prior final joint custody decree upon the request of one or both of the joint custodians or whenever it determines that joint custody is not in the best interest of the children. If modification of the terms of the plan for joint care, custody, and control approved by the court and incorporated by it into the final joint custody decree is attempted under division (B)(2)(a) of this section and the court rejects the modifications, it may terminate the final joint custody decree if it determines that joint custody is not in the best interest of the children. If the court proposes a modification to a final joint custody decree under division (B)(2)(b) of this section and the joint custodians do not agree to the modification, the court may terminate the final joint custody decree if it determines that joint custody is not in the best interest of the children.

(e) Upon the termination of a provisional joint custody decree or a prior final joint custody decree under division (B)(2)(c) or (d) of this section, the court shall proceed and issue a modified decree for the care, custody, and control of the chilren under the standards applicable under division (A) of this section as if no decree for joint care, custody, and control had been granted and as if no requrest for joint care, custody, and control had ever been made.

(C) In determining the best interest of a child pursuant to this section, whether on an original award of custody or modification of custody, the court shall consider all relevant factors, including:

(1) The wishes of the child's parents regarding his custody;

(2) The wishes of the child regarding his custody if he is eleven years of age or older;

(3) The child's interaction and interrelationship with his parents, siblings, and any other person who may significantly affect the child's best interest;

(4) The child's adjustment to his home, school, and community;

(5) The mental and physical health of all persons involved in the situation.

(D) The parents of any children may request the court to grant them joint care, custody, and control of the children in a proceeding held pursuant to division (A) of this section. If a request for joint care, custody, and control is made, the parents making the request shall file with the court a plan for their exercise of joint care, custody, and control of the children. The plan shall be filed with the petition for dissolution of marriage, if the question of care, custody, and control arises out of an action for dissolution of marriage, or, in other cases, at a time at least thirty days prior to the hearing of the issue of the care, custody, and control of the children. A plan for joint custody shall include provisions covering all factors that are relevant to the care, custody, and control of the children, including, but not limited to provisions covering factors such as physical living arrangements, child support obligations, provision for the children's medical and dental care, school placement, and visitation.

(E) "Joint custody" or "joint care, custody and control," as used in the Revised Code, means that the parents share, in the manner set forth in the parents' plan for joint custody that is approved by the court, all or

some of the aspects of physical and legal care, custody, and control of their children.